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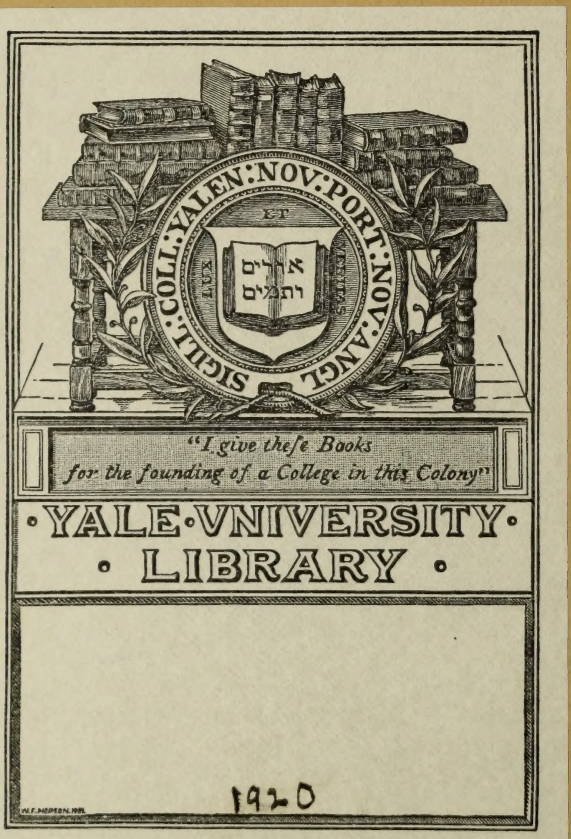


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## THE NECESSITY OF DIRECT EXAMINATION OF THE LOWER BOWEL FOR THE DIAGNOSIS AND TREATMENT OF DIARRHEA.*

*By G. Milton Linthicum, A.B., A.M., M.D.*

Professor of Diseases of Colon and Rectum, Baltimore Medical College; Former President Medical and Chirurgical Faculty of Maryland.

In selecting such a title for my remarks, I do it realizing the latitude of the possibilities which might be included under such a title, but shall confine myself to the meaning of diarrhea, regarding it from its Greek derivation "to flow through," or an abnormal frequency and liquidity of fecal discharges, entirely as a symptom of disease and not a disease *per se*.

While medical literature treats it as a distinctive disease, offering various descriptive names to it suggestive of its cause, this by virtue of long usage has made it authoritative, yet, at the same time, has had a tendency to cloud the situation and rob it of very great significance as a symptom in many serious troubles which should be investigated with the greatest attention and exactitude.

I may not offer you anything new, but I hope to collate under this title some of the facts which associates diarrhea as a symptom, and thereby call more attention to the possible factors which often bear causative relations to its production.

As is well known, diarrheic stools are caused by the increased amount of fluid in the stools, due to some factor which upsets the equilibrium between the absorption and excretion of the water in the small or large intestine; or causes increased peristalsis, which hurries the contents with such rapidity as to not permit of absorption.

This abnormal or exaggerated peristalsis may be produced in a number of ways without any marked anatomical changes in the intestine; such cases are usually confined to the small intestine and are due to more or less known etiological factors, and are known as fermentative, lienteric or irritative diarrheas. It is in these forms of diarrheas that recognition is comparatively easy, and

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the treatment usually correct from the mere recital of the case history by the patient. It is they which have given to us the security of a correct opinion, and have made us more or less careless in dealing with all diarrheas.

On the other hand, diarrheas are due to pathological peristalsis, caused by anatomical changes in the intestine; in such cases the diarrhea is a symptom of the diseased intestine. It is to these conditions I will attempt to direct attention, for it is in them that the true causative factor is often not recognized. I have found that the existence of more than two weeks' duration of any diarrhea is extremely suggestive of these anatomical changes, to determine the character and treatment of which I cannot emphasize too strongly the necessity of direct examination of the lower bowel through some form of apparatus which will permit of the inspection of the lesion itself.

One so often finds diarrheal discharges treated without any examination whatever to determine its real character; indeed, until recently the rectum seemed to be the last point to be investigated intelligently.

I recall myself operating only recently for a malignant growth, and in another for a syphilitic stricture, both of which had been treated surgically for hemorrhoids without investigating higher up, which should direct our attention even in treating cases with external maladies to the possibility of other existing conditions. In both of these cases, however, were diarrheal discharges which were not attributable to the hemorrhoids.

Neither macroscopic nor microscopic examination of the feces, upon which so much stress has been laid in the past, presents conclusive results.

The presence of undigested food regarded as a clinical symptom of small intestinal involvement is not positive, as not infrequently irritative lesions of the lower bowel may reflexly stimulate peristalsis in the upper tract, causing too rapid passage of its contents before digestion is complete into the diseased lower bowel, from which it is expelled.

The presence of mucus, when admixed with feces, is suggestive of involvement of the small intestine, and when coating the feces large intestinal involvement; yet its presence is of little value, for almost any irritation in the tract may cause its excessive secretion.

The presence of pus or blood is a positive sign of ulceration of some variety, but does not indicate the character or location of the lesion, nor does its absence negate the presence of lesions which have not undergone ulcerative changes; nor does it occur in the early stages of malignant or benign growths.

Pain is most often depended upon as an index to intestinal involvement, and is the predominating influence which brings the patient to the physician and directs the physician to a more careful investigation than any other symptom. Pain is extremely variable as to time of appearance and significance because of its

origin, the intestine being comparatively insensible to pain, except that brought about by pressure and increased motility of the musculature, which has been demonstrated by Dr. Arthur N. Hertz in his experiments upon the intestines, and described by him in the Goulstonian lectures March, 1911, under the title of "The Sensibility of the Alimentary Canal."

These experiments showed pain to be only produced in those diseases which were accompanied by abnormal or exaggerated motor activity, or in those diseases or conditions when there was distension of the stomach, small or large intestine; this distension being due to accumulation of gases or other intestinal contents, a condition often found in acute and chronic catarrhal colitis. Here the pain is more fullness and not the acute lancinating variety of peritonitis; it is rather a sense of uneasiness and is accompanied usually by diarrhea, caused by increased peristalsis.

On the other hand, ulceration, which at the beginning may have caused diarrhea and pain when not having involved adjacent viscera and not produced obstructive conditions, will in the absence of diarrhea be free of pain. Hertz has demonstrated that the pain which is caused by the passage of the intestinal contents over the ulcers is not due to the contents coming in direct contact with the ulcers, but to stimulation of the exposed nerve endings, "which are, because of their exposure, more sensitive," causing reflexly a spasmodic contraction of distal portions of the intestine, thereby increasing pressure within the intestines and, at the same time, the exaggerated peristalsis is urging the contents down against a spasmodic stricture. From this we may well gather that so long as the free passage of intestinal contents is not interfered with, or adjacent viscera involved, the symptom of pain will be absent in ulceration.

The pain one finds in malignant growths is not present until the tissues and adjacent viscera are involved, or until the growth has attained a size sufficient to produce more or less obstruction symptoms which dam back the fecal stream.

The diarrhea which results from the presence of malignant growths oftentimes occurs long ahead of the pain symptoms because of the presence of the growth acting as an irritant, increasing the blood flow to the parts with increased water elimination and, at the same time, stimulating peristalsis so as not to give time for intestinal contents to remain long enough in the colon for absorption of liquid elements by the blood stream.

Thus there is a contribution of the two factors in producing diarrhea in this condition, one of which in itself is sufficient. No doubt because of this we get what is termed the "explosive diarrhea," characterized by its intermittent nature of alternating with constipation. The importance of this symptom is its early appearance, and, with the exception of constipation, it is perhaps the earliest to appear, followed later by the usual pain; bloody and purulent discharges indicating by their appearance such great in-

volvement and destructive changes as to make the recognition of the trouble too late to be of much value for permanent relief by the only possible method of a hoped for cure—namely, operative.

The study of malignant growths of the intestinal tract shows them in the form of carcinoma, sarcoma and lympho-sarcoma, with carcinoma in its several varieties being the most frequent variety. In a series of 26,340 cases of carcinoma in the body generally, compiled by Maydl, Heimann, Zeimann, Nothnagel and Müller, it was found that 2255, or 8.56 per cent., were in the intestinal tract, with the predominant number in the colon and rectum.

Of 659 cases of intestinal carcinoma collated by Maydl, Nothnagel, Zeimann, Müller and Bryant, it was found that 6.22 per cent. were in small intestine, 6.82 per cent. in the cecum and appendix, 22.76 per cent. were in various portions of the colon and 64.18 per cent. in the sigmoid and rectum.

In a series of 1029 cases occurring in the rectum and sigmoid, the growth was located in the anus and rectum 901 times and in the sigmoid 128 times.

Thus, from these figures it is readily seen that an inspection can be made by direct examination in nearly 65 per cent. of all intestinal carcinoma at a time when the removal of the growth offers a fair hope of permanent relief, for it is generally felt by operators that there is less tendency to metastases in the lower bowel than in the other parts of the tract.

There is yet another phase in the consideration of malignant growths suggested by an observation made by Nothnagel which to me, in a study of the subject, seems extremely probable that as a graft carcinoma in the intestines may begin on old ulcer scar tissue, as we know to be the case in gastric carcinoma. For it can hardly be considered a mere coincidence to find that the frequency of location of growths, decubital or stercoral ulceration and strictures corresponds as closely as do these three lesions in the cecum, appendix, colon, sigmoid and rectum.

In these locations a correspondence of frequency is found in direct proportion to the consistency and length of stay of feces; no doubt due to injuries of the delicate mucosa by hardened feces causing subsequent inflammatory changes.

I cannot see how anyone can gainsay the fact that there is certainly more than a suggestive relationship between ulcers in the bowels and carcinoma. However, two-thirds, fortunately, of the bowel when these lesions are located can be directly inspected by the illuminated colon tube, and such ulcers can be seen, treated and most often cured.

It seems, therefore, fair to assume at least that the cure of these ulcers may later prevent secondary degeneration into carcinomata, and to state with certainty that strictures of non-malignant character are often the resultant of ulcers. The decubital or stercoral ulcers are caused by the hardened feces producing pres-

sure necrosis of the superficial mucosa, later purulent inflammation of the submucous membranes resulting, doubtless, from infection of various suppurative organisms. This form is almost entirely confined to the lower bowel, located especially in the flexures and rectum, with the appendix, however, a frequent site to which, no doubt, the inflammation of this organ is often due.

In the rectum they are numerous, producing a very extensive involvement; hence are usually described under the title of "proctitis ulcerosa." They are characterized by a very definite circular outline when isolated, but have a tendency to coalesce and unite, healing by cicatrization and contraction and resulting frequently in stenosis of the intestines. Following the stenosis, there is more marked stasis because of the obstruction, with later very pronounced ulcerative changes occurring in the mucosa above the stenosis, forming Kocher's "distension tumors." The mucous membrane lining of these sacs becomes thinned by distension, and because of the pressure and irritation of retained feces become punctured with ulcers due to destructive necrotic changes, to which ulcerated areas he applies the name "distension ulcers." (*Dehnungs-Geschwüre*).

It is to these strictures of the bowel that a syphilitic origin has almost universally been given, but now are regarded more frequently as being due to scar tissue of ulcerated areas; but it is in these cases of strictures that one often finds carcinomatous changes taking place, and to which Nothnagel refers in his observation as mentioned above.

The other groups of ulceration presenting diarrheal symptoms are those occurring occasionally as a result of catarrhal inflammation of the mucosa, either acute or chronic. They are usually termed catarrhal when beginning in the mucous membrane, and follicular when their origin is in the lymphatic follicles. The latter are largely confined to the upper rectum and sigmoid, because the solitary follicles are chiefly limited to this part of the tract.

The appearance of follicular ulcers may be that of the isolated round punched-out class, or may be so confluent as to involve almost the entire lining of the intestine. The early stage appearance is suggested by the manner of their development, each follicle having an opening on the surface extending into a minute cavernous excavation; later the lesion appearing as an inverted funnel, with its base gradually extending out by destructive changes, undermining the mucous membrane so that shreds as of a ragged curtain hang over the ulcerating depression.

As the disease progresses, the further involvement of deeper layers takes place, involving submucosa even into the musculature and may go on to perforation. Healing may take place in the early stage with only moderate destruction of tissue, or stenosis may occur. If the destruction is very great, the lesions do not heal, but remain as an extensive ragged surface, discharging pus and blood admixed with loose fecal discharges.

The simple catarrhal ulcers developing in the mucous membrane are really distinctive only pathologically, as the catarrhal and follicular are nearly always found associated when the trouble is at all severe. In mild forms of ulceration there may be present only small erosions of the mucosa confined to the superficial layers. Where severe forms are encountered the ulcerations become merged and present large suppurating areas with marked involvement of the mucosa, and may extend even into the muscles, but rarely cause perforation. The same general symptoms and visual picture through the sigmoidoscope are found in both of these varieties.

Primary tubercular ulceration is a very rare occurrence, and when found is almost always confined to young children and nurslings. In the Charite Hospital of Berlin, in 3104 cases of tuberculosis in children, there were only 16 of primary intestinal infection. The consensus of opinion is that infection is due to tuberculous milk. The variety of primary cases in adults is shown by the Munich Pathological Museum presenting only about one case in 1000 autopsies. The early symptoms are usually colicky pain with irregular diarrheas.

Tubercular ulceration secondary to lung involvement is of frequent occurrence, as shown by its occurrence 566 times in 1000 Munich autopsies of tubercular cases involving either the ileum, colon or cecum, from which points ulcerations may extend upward, but more often extend downward into the colon and sigmoid. They nearly always begin in the solitary follicles and later involve the mucosa.

The appearance of a tubercular ulcer is that of an irregular patch with usually swollen or undermined edges, as a rule of a light red color. The base presents a peculiar greasy appearance made up of varying stages of degeneration. The tendency of the ulceration is to spread and to involve adjacent areas, and at the same time to set up inflammatory changes in the serosa, so that localized peritonitis is nearly always present. The infrequency of primary ulcers of tubercular origin and the frequency of secondary development makes a diagnosis of tubercular ulcerations comparatively easy when found associated with the tubercular involvement of other organs.

Syphilitic ulceration of the intestine other than the rectum is rarely ever seen, although several cases have been reported in adults by Meschede, Klebs, Oser and Birch-Hirschfeld as occurring in the small intestine. They are frequently, however, encountered in the rectum as a rule, confined to the lowermost part just inside the sphincters. Their usual appearance is a very shallow depression with edges infiltrated and hard, having a grayish white color.

Virchow especially calls attention to the slight depth and smooth base as a distinguishing feature between syphilitic and dysenteric ulcers. Birch-Hirschfeld lays stress upon the peculiar cicatricial

induration in the immediate vicinity of syphilitic ulcers, which is less pronounced in dysenteric. The light-red margins of the tubercular ulcer is a distinguishing feature when compared with the grayish-white margin of the syphilitic. The great value of recognition of these ulcers is that the persistent diarrhea will only yield to anti-syphilitic treatment.

Furthermore, luetic ulcerations have apparently a greater tendency to form severe rectal strictures. Ulcerations occurring in the course of typhoid, diabetes and nephritis furnish the usual characteristics of the stercoral ulcers, and the symptoms occurring during the disease are similar. Ulcerations occurring in dysentery are usually due to the ameba dysenteric. These ulcerations are divided into three classes, which are probably stages in their development. The pre-ulceration stage presents the "small red spots" of Rogers from .2 to .5 m.m. in diameter, with moderate congestion of the mucosa and not much involvement of the submucosa.

The second stage, or the type of Harris, gives a punched-out appearance, round or oval in contour, with thick and congested edges; the third stage, usually the one seen, is known as the undermined ulcer and appears early as minute white or yellow spots in congested areas. Under these spots or openings are found cavities filled with necrotic tissue buried in the submucosa. From these areas extensive burrowing takes place, destroying the mucous and submucous layers, and even the muscles. These ulcers are confined almost entirely to the large intestine, involving the entire colon and upper rectum.

Of the symptoms of ulceration of any variety the one of paramount importance is the diarrhea, which is usually of the early morning variety, appearing first on rising, again after eating and frequently during the forenoon, after which there is comparative comfort.

When we recall that increased peristalsis or lack of absorption of the fluid, or both, are responsible for diarrhea, we can readily see that the majority of diarrheas caused by ulceration are due to their location in the large bowel, and, furthermore, the strongest probability is that the ulceration exists below the cecum and ascending colon. This fact is easily understood, for as long as there is sufficient of the large bowel intact and healthy, the absorption of water proceeds in a physiological manner.

The location of ulcers in the small intestine, cecum or ascending colon, unless complicated with catarrh of the intestine or some form of infection to stimulate exaggerated peristalsis, will rarely evidence diarrhea.

Examinations through the sigmoidoscope will permit of smears being made of the ulcerated areas and microscopic examination made, so that recognition of the tubercular bacilli, the spirocheta pallidae or ameba can be readily determined by microscopic examination and correct treatment instituted.

Gonorrheal proctitis is a comparatively rare occurrence, but may occasionally be seen, and is most frequent in women. It has been my fortune to see only one case; this involved the entire rectum up to the beginning of the sigmoid. The diagnosis was confirmed by the finding of the germ of Neisser. The patient applied for treatment because of frequency of stools, which were admixed with sanious pus.

Strictures, stenosis and growths of benign or malignant type usually present obstructive symptoms earlier than the diarrhea, usually with constipation alternating with diarrhea. This is due to the accumulated feces acting as an irritant and stimulating peristalsis producing diarrheal stools. If ulceration has taken place, pus and blood are found in large quantities. A direct examination will show the presence of the trouble and its removal may be instituted.

The treatment of ulcerative cases can be made directly to the parts effected through the tube, either by probangs or by the atomizer. Small growths of a benign nature may be removed with a snare. Growths suspected of malignancy may have a bit snipped off for examination.

To summarize in a few words:

1. Diarrhea should be regarded as a symptom of disease.
2. All chronic or sub-acute diarrheas are due to some form of a pathological lesion.
3. The character of the diarrheal discharge, while helpful in making the diagnosis, cannot be depended upon either to indicate the nature or location of the lesion.
4. Pain as a symptom is very misleading, as it is frequently absent in the most serious and present often to a marked degree in lesser lesions.
5. The necessity of direct examination is of the utmost importance, as early recognition in malignant growths gives the only hope of permanent relief.
6. The treatment of diarrheas locally in conjunction with systemic is essential.

817 Park Avenue, Baltimore, Md.

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THE PHYSICIAN'S VISITING LIST. 1913. Philadelphia: P. Blakiston's Son & Co. Leather, $1.25.

Blakiston's Visiting List for 1913 contains all the valuable features of its predecessors. The one before us contains space for the entry of 25 patients per day or week, besides pencil, pockets, table of signs, table of incompatability, scheme for immediate treatment of poisoning, the metric or French decimal system of weights and measures, table for converting apothecaries' weights and measures into grams, physician's dose table, and other attractive features. As heretofore, it should meet the demands of the practitioner as a handy and useful method of keeping track of his daily work.

# THE PROPHYLACTIC VALUE OF VACCINES IN TYPHOID FEVER.*

*By J. Clement Clark, M.D., Superintendent,*
Springfield State Hospital for the Insane, Sykesville, Md.

It is not the purpose of this paper to enter into a discussion of the etiology, diagnosis, prognosis or treatment of typhoid fever. They are too well known to all of you, typhoid fever having been a prevailing disease in certain seasons of the year in different sections of the country for more than a century; attacking, as a rule, young and vigorous people in the prime of life, and causing not only loss of life, but great suffering and financial loss to the individual and to the State. Statistics go to show that about 350,000 cases occur in the United States annually, and the financial loss is variously estimated at about $35,000,000. The extent to which typhoid fever is prevalent is often taken as a fair criterion of the development of sanitation in the community. While this is true to a certain extent, there have been epidemics in communities the origin of which could not be definitely ascertained. In the last few years it has been discovered that a certain percentage of those who have suffered from typhoid fever harbor for an indefinite time the typhoid bacilli in their intestinal tract, being thus a constant source of danger in spreading the disease. The typhoid carrier is an unknown quantity in the community, and unless laboratories can be established in almost every town and the feces of all patients who have had typhoid fever examined from time to time, it would seem an insurmountable task to find the typhoid carriers, and again, if found, the pathogenesis of the carrier state is unsolved and the treatment unsatisfactory, many drugs and methods having been tried and found wanting. It has also been the general belief that when the water and food supply of a community are pure and the sewerage properly cared for, typhoid fever did not prevail. This has often proven fallacious, and in spite of our improved sanitation typhoid fever still stands out as a preventable disease that we do not prevent, and we must look for some further means.

Twenty years ago those of you who are residents of this portion of the State would have thought that malaria could be stamped out by any other means than by looking into the soil, so strong and fixed was the belief that it was a miasmatic disease. We now know that it is a parasitic disease, and we need only make a blood preparation and examine it with the microscope, and if we find the malaria parasite we have positive proof that this particular individual is a carrier of the infectious malarial organisms, and to make this malaria carrier harmless is not difficult. In quinine we have an antidote to kill the parasite with, and if

*Read at the Semi-annual Meeting of the Medical and Chirurgical Faculty at Cambridge, November 12, 1912.

With the brilliant results obtained in the United States Army in the late encampment of 20,000 troops at Santiago and along the Mexican frontier, during which only two cases of typhoid were recorded, the results recorded in the large hospitals among the nurses and attendants and the results obtained in several typhoid fever epidemics in different parts of the country, it would seem that more proof of the value of vaccination as a preventive measure in typhoid fever is not needed. However, its use is somewhat *sub judice* and still more witnesses should be heard. We do not know as to how long the immunity lasts, it having been variously estimated from six months to three years. From our experience at the hospital, it has certainly been good for 18 months, as that length of time has elapsed since the first inoculations without a single case occurring among the inoculated.

Major Russell's conclusions in his article published in the journal of the American Medical Association are all borne out by the results of our experience at Springfield. The conclusions are: (1) "That the inoculations are harmless in healthy persons is now well established." In our own cases not a single ill-effect has been discovered among the 1316 inoculated, 890 of whom have been under daily observation by our assistant physicians for 18 months. (2) "That it confers almost absolute immunity against infection." Our typhoid rate has been reduced from 1 to 2 per cent. to nothing. (3) "That it was the cause of immunity of our troops against typhoid fever in the recent Texas maneuvers." (4) "That the duration of immunity is not yet determined, but it is assuredly two and one-half years and probably longer." Immunity has lasted among the 890 vaccinated in 1911 for 18 months. (5) "That only in exceptional instances does its administration cause any appreciable degree of personal discomfort." All our patients were up and ready for breakfast the morning after the inoculations with eight exceptions. (6) "That it apparently protects against the chronic bacillus carrier and is at present the only known means by which a person can be protected against typhoid under all conditions." All known precautions, as boiling water and milk, disinfecting stools, sterilizing clothing, screening the windows, etc., had been tried, but still a few cases developed each fall. (7) "That all persons whose professions or duties involve contact with the sick should be immunized." It is a well-established fact that attendants and nurses are more liable to typhoid infection than those engaged in other occupations—eight times as liable according to the statistics of the Massachusetts General Hospital. (8) "That the general vaccination of the entire community is feasible and could be done without interfering with the general sanitary improvements, and should be done where the typhoid rate is high." This is a safe and sane proposition. Considering the harmlessness and safety of the use of typhoid vaccines, there is no reason why typhoid vaccination should not be compulsory, just the same as smallpox vaccination. Certainly

every case of typhoid that is prevented lessens the liability of the infection of others, both by the possible contact and the various channels of transmission while sick, as well as the possibility of his becoming a typhoid carrier after convalescence.

[NOTE.—I am indebted to my assistants for carrying out the technique and recording the results from various cases.]

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DISEASES OF THE STOMACH, INTESTINES AND PANCREAS. By Robert Coleman Kemp, M.D., Professor of Gastro-Intestinal Diseases in the New York School of Clinical Medicine, late Gastro-Enterologist to the New York Red Cross Hospital, Gastrologist to the West Side German Dispensary, Consulting Physician Gastro-Intestinal Diseases to the Manhattan State Hospital, Member American Medical Association, Academy of Medicine, etc. Second edition. Revised and enlarged. Octavo of 1021 pages, with 388 illustrations. Philadelphia and London: W. B. Saunders Company. 1912. Baltimore: The Medical Standard Book Co. Cloth, $6.50 net; half morocco, $8 net.

The stomach and the intestines are the root of so many evils that a book presenting the disorders of these structures in a succinct, clear, scientific manner is indeed a boon to the general practitioner. Perhaps nobody better then the family physician realizes the number of ills which can be traced directly to a disordered gastro-intestinal tract. If the stomach is out of commission, the rest of the body participates as a result of improper nutrition. Consequently, a healthy condition of this system is much to be desired, and it is the function of the above-mentioned volume to educate the profession in bringing the gastro-intestinal canal back to normal when diseased. Besides the features of the first edition, the present embraces chapters on colon bacillus infection and diseases of the pancreas. The reviewer concurs in the belief of the author that the true gastric neuroses are extremely rare and, like the writer, attributes obscure gastric disturbances to disease of the gall-bladder, appendix, etc. The book is replete with good sound advice; for instance, in the chapter on appendicitis when speaking of the treatment, the author advises complete abstainal from food until the temperature reaches 100° Fahr. This is excellent and safe advice, but to our way of thinking food had better be withheld until it reaches practically normal. We entirely concur with his belief that if symptoms warrant, operation should be done early. The section of the book, however, which no doubt will be found most instructive is that on the treatment by mechanical means of the visceral ptoses. So much good can be done by proper mechanical appliances in association with guarded exercises to the sufferers with fallen internals and the author has put the subject so plainly, intelligently and simply that every physician should read what he has to say. The remainder of the book also is of the highest order.

# HERNIAS OF THE OVIDUCT, OVARY AND OVIDUCT AND OVARY

*By Aimé Paul Heineck, M.D.,*

Surgeon to the Jefferson Park Hospital, to the Grace Hospital and to the Cook County Hospital, Chicago. Professor of Surgery, Bennett Medical College, Loyola University.

In the female, the frequency of hernias, and especially of hernias of the internal genitalia, has been and is still underestimated. Owing to the lack of study heretofore given to this clinical entity, hernias of the uterine adnexae are often overlooked, not uncommonly misdiagnosed, and therefore subjected to injudicious treatment; harmful alike to the individual and to the hernial contents, prejudicial alike to the patient's general well-being and to her reproductive powers. Impressed by the clinical importance of the condition and surprised at the insufficent consideration given to the subject in even the most modern gynecological and surgical text books, I have collected the following data, which may prove of service to some of my professional colleagues as well as to future investigators of the subject. Knowledge of the occurrence and familiarity with the symptomatology of a clinical condition lead to its more frequent and more timely recognition.

Soon after beginning the consideration of the subject, we became convinced that deductions and conclusions to be valuable should be based solely upon the study of cases whose accuracy of diagnosis is self-evident. Therefore, in the preparation of this paper we have only considered cases in which the hernial contents were demonstrated at the dissecting, autopsy or operating table.

We have conformed to the nomenclature in actual use; however, to better insure precision of classification and a more intelligent discussion of the subject, we define, perhaps needlessly at times, the terms employed. The word hernia signifies the permanent or temporary protrusion of one or more viscera from their normal situation through a normal or abnormal opening in the walls of the cavity within which they are contained. It implies the existence of a hernial ring, of a hernial sac, of hernial sac contents and of sac coverings. In the hernias discussed in this article, the protruding organ was always either an ovary, an oviduct, or Fallopian tube and an ovary. In some cases, as associated hernial contents we find omentum, a segment of the ailmentary canal, a part of the urinary bladder, a rudimentary uterine horn, or the entire uterus, be the latter organ rudimentary, infantile or of normal development. The tube or ovary or both in part or in their entirety may be herniated. All the hernias herein considered are external hernias; that is, their outermost overlying saccular covering is skin, and each, after reaching a certain stage of development, gives rise to a more or less visible,

more or less palpable external swelling in the inguinal, femoral, ventral, obturator or ischiatic regions, depending upon the anatomical location of the hernia. Internal hernias, that is hernias in which one or more loops of intestine find their way into pouches or recesses in the posterior peritoneal wall, and diaphragmatic hernias, be the latter true or false, congenital or acquired, constitute other chapters of surgery.

The escape of the uterine appendages from their normal situation may take place through any of the weak spots or openings of the lower abdominal or abdomino-pelvic cavities. A hernia originating either in the internal or in the external inguinal fossae and escaping above Poupart's ligament is an inguinal hernia; if escaping beneath the same ligament, it emerges through the crural canal and the saphenous opening, it is a femoral hernia; if through the obturator canal, an obturator hernia; if along the course of the gluteal or sciatic nerves and vessels, emerging almost always above, very infrequently below the pyriformis muscle, very rarely through the lesser sacro-sciatic foramen, a gluteal hernia; if through an operative scar in the abdominal wall, a post-operative hernia.

Though sanctioned by long usage, the classifying of hernias into congenital and acquired is, at times, misleading. It is misleading because it is practically impossible to determine the congenital or acquired nature of many hernias. Furthermore, the term congenital hernia, as now used, does not imply in the female that the hernia was present at birth, as it is also applied to hernias whose post-natal development is due to predisposing conditions of congenital origin; developmental defects, persistence of transitory embryonal or fetal states which, owing to their non-disappearance with growth, permit the occurrence of outward visceral displacements. Some hernias are congenital in the truest sense of the word; they are complete at birth, hernial contents being then present. In most of the so-called congenital hernias, the sac only is existent at birth; in an acquired hernia, the sac is always of post-natal development, and in all but hernias par glissement is entirely derived from the parietal peritoneum. Congenital hernial sacs result from the want of closure of peritoneal processes, such as the processes vaginalis peritonei in the male, the canal of Nuck in the female, etc., normally present in the fetus. Congenital hernias may appear at any period of life.

Orifices for the transmission of vessels and ducts are normally present in the muscular and aponeurotic layers of the abdominal walls. An acquired hernia is formed by the gradual or sudden escape through these orifices, pathologically widened, of viscera normally contained within the abdominal cavity; the viscera in their passage through and beyond the abdominal wall create paths of escape for themselves by bulging and pushing forward the parietal peritoneum.

In many cases, the congenital or acquired nature of the hernia

is either too vaguely stated or is left unmentioned. Femoral hernia seldom occurs before adult life.

Tubal, ovarian and tubo-ovarian hernias occur in the colored and in the white race. Commonly, the condition is unilateral; infrequently, it is bilateral. When bilateral, the hernias may or may not be developed to the same degree on both sides. The bilaterality may date from birth; may be acquired. In the latter case, the hernias may from the first have been bilateral or an interval of time of shorter or greater length may have intervened between the appearance of the two hernias. In Broca's case, when patient was eight months old, the right inguinal hernia appeared, but the left inguinal hernia did not become manifest before the patient was four years of age. All the bilateral, tubal, ovarian or tubo-ovarian hernias recorded in the medical literature of the last 20 years are of the inguinal variety. This is in accord with a well-known fact that in both sexes double femoral hernias are less frequent than double inguinal hernias.

A tubal, an ovarian or a tubo-ovarian hernia may co-exist with one or more hernias of other organs. Multiple hernias are not infrequent, the hernias present being either of the same or of different types, as two inguinal hernias or one inguinal and one femoral hernia on the same or on opposite sides of the body.

The hernias which we have under consideration may or may not be associated with non-development, malformation or absence of the other internal, or of some external genitalia. In Martin's (Kossmann) case, a hernia of the left tube and ovary, the uterus was displaced upward, forward and to the left by a cyst of the right ovary having the volume of a man's head.

In almost all the cases the operation performed was a herniotomy, and as herniotomy affords little opportunity for direct examination of the pelvic organs, the condition of the non-herniated genitalia was determined in only a few cases.

Hernia is a widespread disease. The relative incidence of hernias of the internal genitalia as to age corresponds to that of hernia in general. In our series, the youngest patient was four weeks old at time of operation. Nicoll operated successfully for ovarian hernia on two infants, each one and a half months old. The oldest patient operated on was 78 years old. She had a left tubal obturator hernia. Lickley reports a right tubo-ovarian obturator hernia observed in a dissecting-room subject who had died of general debility and hemiplegia at the age of 87 years. In many cases the age is not stated. The age given by most authors corresponds to the age of the patient at the time of operation and not to the age at which the hernia first appeared.

The study of the reported cases demonstrated:

(a) The frequency of hernias during the first year of life.

(b) The rarity of the condition from the first to the fifteenth year of life.

(c) The noticeable progressive increase in the number of

hernias observed from the fifteenth year on, the maximal frequency being seen during the fourth decade of life.

(d) After the fortieth year, there is a decline of the number of hernias; they become relatively rare as the extremes of life are approached.

During the child-bearing period, hernias of either or of both uterine appendages have been observed in nulliparae, in primiparae and in multiparae.

*Etiology.*—The predisposing and exciting causes of tubal, ovarian and tubo-ovarian hernias are shown by an analysis of the collected cases to be the same as those of other hernias in the female. The persistence of the canal of Nuck is an etiological factor of the greatest significance in the causation of inguinal hernias. The canal of Nuck, the homologue of the processus vaginalis peritonei in the male, is a peritoneal diverticulum accompanying and adhering intimately to the round ligament, descending in some cases as far as the insertion of that ligament in the labium majus. This peritoneal process, whose dates of origin and disappearance are not accurately known, is usually found completely obliterated at birth; it may close after birth; it may even persist throughout life. When the canal of Nuck is only partially or completely unobliterated, it forms a potential hernial sac and is conceded to be the most important congenital predisposing cause to inguinal hernia formation. It is a matter of common knowledge that preformed sacs are not of infrequent occurrence in the inguinal region. They have been found in other hernial regions. A sudden or forcible increase in intra-abdominal pressure, such as can be determined by muscular effort, by a misstep in an attempt to save one's self from falling, can lead to hernia formation by causing the irruption in a preformed sac of a tube, an ovary or a tube and ovary. As during infancy, the internal genitalia can neither be displaced by their physiological activity, which is nil, nor by the development of pelvic tumors (rare during early childhood), nor by muscular effort, it follows that hernias of the uterine appendages, at that period of life, are due to such congenital anatomical defects as facilitate tubal, ovarian or tubo-ovarian displacement.

Though, as an etiological factor in the production of hernias, the existence of hereditary predisposition is denied by some authors, to us the influence of heredity appears positive. Hernia being a malformation often due to developmental arrest, such as non- or incomplete obliteration of the processus vaginalis peritonei, non-obliteration of umbilical ring, etc., it is subject to hereditary transmission. It is reasonable to assume that like structural characteristics beget a like predisposition and a like resistance to hernia development. Among other etiological factors should be mentioned:

1. All conditions associated with increased mobility of the uterine appendages:

(a) Lengthening of the broad ligaments consecutive to repeated pregnancies.
(b) Pathological relaxation of the ligaments due to puerperal sub-involution.
(c) Abnormal length of the broad, ovarian and infundibulo-pelvic ligaments.
(d) Relaxation of the other tubal, ovarian and uterine ligaments.

2. All conditions that tend to increase the intra-abdominal pressure:
(a) By overcoming the resistance offered by one or another of the weak points of the abdominal wall.
(b) Occupations necessitating repeated muscular efforts associated with increased intra-abdominal tension, as the lifting or pushing of heavy weights, etc.
(c) Physiological or pathological states which distend the abdominal cavity, which stretch the abdominal parietes and widen the orifices normally present in the muscular and aponeurotic layers of the abdominal wall: Enteroptosis, obesity, abdominal tumors, ascites, pregnancy, etc.

3. All conditions which weaken the abdominal wall:
(a) Acute or chronic diseases debilitating the organism.
(b) Obesity.
(c) Traumatism.
(d) Enteroceles, epiploceles and entero-epiploceles.
(e) Feeble development or atrophy of the aponeurosis of the transversalis muscle and of the conjoined tendon.
(f) A shortening of the round ligament of the hernial side.

*Hernial Sacs.*—Congenital hernias have sacs of prenatal formation. That the canal of Nuck remains patent in many cases long after birth, even into adult life, has been proven by a number of investigators. Acquired hernial sacs are formed of parietal peritoneum forced by intra-abdominal pressure through some congenital or acquired defect in the abdominal walls.

In the female the following anatomical characteristics are strongly suggestive of the congenital sacs: Great vascularity, absence of sub-serous fat, folds, valvular or diaphragmatic constrictions, cyst-formations, scarlike induration of the wall, etc. In congenital inguinal hernias, it is also noted that the round ligament is intimately adherent to the sac.

As we see, the sac results from the bulging outward of the parietal peritoneum without solution of continuity. It consists of a neck, body and fundus. Of these three, the neck is the most important. It is through it that the general peritoneal cavity communicates with the hernial sac cavity. It may be the site of constriction. The fibrous envelope of the sac is due to the

condensation of the fibrous layers which the hernia in developing pushes forward.

The internal surface of the sac, whether the latter be congenital or acquired, has all the peculiarities of serous membranes.

In the female, encysted inguinal hernias result from partial closure of the canal of Nuck, the peripheral portion of which is transformed into a cryst in which a developing hernia prolapses or from the sinking of a hernia in pre-existing hernial hydrocele.

There is really no sacless hernia; but the herniated viscus may be an organ only partially covered with peritoneum.

In sliding hernias, the anterior and lateral portions of the sac are, as in ordinary hernias, derived from the parietal peritoneum, while the remaining portion is formed by the anterior surface of the herniated cecum, sigmoid, bladder or Fallopian tube.

Hernial sacs may be dome-shaped, cylindrical, digitiform, sacculated or irregular; may show constrictions with intervening dilated portions. Most femoral sacs are small and not infrequently are embedded in a mass of fat. The sac in recent hernias may be very thin. In children and in young infants, sac is extremely thin.

*Hernial Fluid.*—The reporters not infrequently state that fluid of some nature or other was present in the hernial sac. The fluid may be serous, sanious, muco-purulent, purulent or fetid in character.

HERNIAL SAC CONTENTS.

*Tubal Hernias.*—The tube, either in part or in its entirety, may be the sole content of the hernial sac. As associated hernial contents, a portion of the urinary bladder, normal intestine, gangrenous intestine and omentum were noted. The herniated tube may be normal and free; may be adherent to sac; may be strangulated; may show inflammatory lesions; may be cystic; may be the seat of a pyosalpinx.

*Ovarian Hernias.*—The ovary may be the only content of the hernial sac; or may be associated with a cystic parovarium, with omentum, with intestine or with a rudimentary uterus. The herniated ovary is reported as being in some cases normal, in others enlarged to twice its normal size, infiltrated with blood, the seat of a large hematoma, adherent to sac, cystic, to have presented areas of suppuration; to have shown gangrenous changes.

*Tubo-Ovarian Hernias.*—Hernias of the tube and ovary constitute the largest number of hernias of the uterine appendages. As associated hernial contents may be mentioned: Urinary bladder, Meckel's diverticulum, the appendix vermiformis, omentum, intestine and the uterus.

We know of only two cases in which gestation occurred in an inguinal hernial sac; both were tubal pregnancies.

The herniated organs may be normal, may show slight or marked pathological changes. The displacement of a tube or of

an ovary into a hernial sac is unfavorable to its anatomical and functional integrity. In a hernial sac, these organs are exposed to repeated slight traumatisms and to circulatory disturbances. The herniated ovary frequently undergoes cystic changes; may show atrophy; may show enlargement; may be undersized.

The herniated tube may be the seat of suppurative salpingitis, of abscess, of tuberculosis; may be adherent to sac by an inflammatory band. We must not forget to state that a tube and ovary present in a hernial sac do not always have the same reciprocal relation that they have in the abdominal cavity, and that the pathological changes which they show may antedate their displacement into a hernial sac.

*Reducible Hernias.*—In reducible hernias, and, at first, practically all hernias are reducible, the hernial contents either return spontaneously into the abdominal cavity when the patient assumes the recumbent posture or they can be manipulated back, with more or less difficulty, but without a cutting operation, into the cavity from which they escaped. Even in reducible hernias, the sac early contracts adhesions to neighboring tissues and becomes irreducible. The terms reducibility, irreducibility, torsion and strangulation have reference only to the hernial contents and not to the sac.

Reposition, spontaneous or manual, may be temporary, may be permanent. Many reducible hernias reappear as soon as the standing posture is assumed; others, to reprotrude, require more or less muscular effort on the part of the patient.

*Irreducible Hernias.*—When the contents of a hernial sac cannot in their entirety be manipulated back into the abdominal cavity, the hernia is said to be irreducible, provided that there is not any or but a very slight interference with the blood supply of the herniated organ or organs, and that there is no disturbance of function. If irreducibility and both, functional and circulatory, disturbances are present, the hernia is designated as strangulated. Irreducibility, partial or complete, predispose to complications of a serious nature: Inflammation, incarceration, strangulation and torsion.

The irreducibility of hernias is dependent upon one or more of the following factors:

(a) Difficulties incident to manipulating a small movable body such as the ovary through a small opening.

(b) Relative narrowness of the hernial canal: Femoral, inguinal, etc.

(c) Sudden increase in size of hernia resulting from some unusual muscular effort.

(d) Changes in the hernial contents: Increase in bulk from deposit of fat, from cyst formation in mesentery, in omentum, from inflammatory or neoplastic changes.

(e) Adhesions of inflammatory origin: (1) Between sac and contents; (2) between the different contents.

(f) Large volume of the hernia.

(g) Sliding hernias (hernias par glissement).

The irreducibility of a hernia of the uterine appendages is due in some cases to the presence as associated hernial contents of the urinary bladder, of the cecum, or of the sigmoid. In other cases, the irreducibility is due to the fact that the layers of the broad ligament, as they leave the Fallopian tube, enter into the formation of the hernial sac.

*Strangulated Hernias.*—All strangulated hernias are irreducible. In addition to irreducibility, they present a constriction of the hernial contents of such a degree as to seriously interfere with the circulation of the blood in the herniated organ or organs. "If the pedicle of a tumor is tied off or if a finger is surrounded tightly by a string, the parts distal to the ligature do not become inflamed; stasis and gangrene result" (Alberts). The same primary changes occur in the contents of a strangulated hernia; the inflammatory changes are secondary to the circulatory disturbances. There is interference first with the venous circulation; then with the arterial. As a result of this interference with the circulation, we have a serous exudate, the amount of which depends upon the degree and duration of the strangulation and also upon the extent of the secreting surface. The sequence of events is as follows: Congestion, stasis, serous exudation, then inflammatory phenomena and gangrene. Strangulation of a herniated tube or ovary is not as dangerous a complication as strangulation of a herniated loop of intestine.

Strangulated inguinal hernias may be congenital or acquired. Strangulation can occur at any age, irrespective of type of hernia or of hernial contents.

As hernial contents can be mentioned the following organs: Fallopian tube, ovary, tube and ovary, tube and a portion of the urinary bladder, tube and a loop of small intestine, ovary and intestine, tube, ovary, intestine and omentum, uterus and adnexe of one side, loop of intestine, uterus and left adnexe.

The symptoms given by the strangulated inguinal hernias are those of inflamed hernias. Symptoms of intestinal obstruction may also be present.

*Torsion of the Pedicle.*—This complication, peculiar to ovarian and to tubo-ovarian hernias, is not of unusual occurrence. As far as we have been able to determine, torsion of the pedicle has been observed only in irreducible congenital hernias of the inguinal type.

The two youngest patients were 4 and 11 weeks old, respectively; the oldest, a poorly nourished child, was 14 months old. All the other patients were less than one year old. The right and left side are involved with about the same frequency. The occurrence of this accident is favored by the mobility of the ovary and the slenderness, at this period of life, of the pedicle of the herniated organ or organs.

The pedicle, usually composed of the Fallopian tube, broad ligament and contained vessels, may have made a half-turn upon itself; may be twisted twice, thrice or several times upon its axis. The pedicle may be twisted in any part of its course.

If unrelieved, torsion of the pedicle determines in the hernial contents anatomical changes similar to those caused by strangulation. The impeded return of blood in the veins leads to congestion and swelling of the organ or organs below the twist. There are noticed in the hernial contents the following circulatory disturbances: Congestion, stasis, thrombosis, vascular rupture (ovary seat of large hematoma) and interstitial hemorrhages. The interstitial hemorrhages and the serous transudates lead to tissue dissociation.

In torsion of the pedicle, the amount, odor and color of the hernial fluid depends upon the tightness and duration of the twist and upon the extent of the gangrenous changes. The fluid present in the hernial sac may be serous; may be blood-stained, dark-colored, reddish brown. Torsion of the pedicle gives rise to symptoms somewhat analogous to those of strangulated intestinal or omental hernias. In fact, the condition has frequently been diagnosed as strangulated intestinal hernia.

*(To be continued.)*

## Book Reviews.

A Textbook on the Practice of Gynecology. For Students and Practitioners. By William Easterly Ashton, M.D., LL.D., Fellow of the American Gynecological Society, Professor of Gynecology in the Medico-Chirurgical College and Gynecologist to the Medico-Chirurgical Hospital, Philadelphia; Formerly Lecturer on Gynecology in the Jefferson Medical College, Philadelphia; One of the Founders of the Congress International De Gynecologie et D'Obstetrique; Member of the American Medical Association, etc. Octavo of 1100 pages.

Nothing speaks so loudly for the popularity of this book as the fact that since 1905, when it was first presented to the medical profession, it has gone through five editions and numerous reprints. The medical profession is very discriminating, and it is soon noised about whether a publication is with or without merit. Therefore, according to this standard of valuation, Ashton's "Practice of Gynecology" has and does meet a definite need. It also augurs well for the profession that our ideas are changing so rapidly that within such a short period of time, so many additions have been made to our knowledge in gynecology as to call forth such a succession of new editions of noteworthy efforts. After a careful perusal of the pages of the present edition the

reviewer has nothing but praise for the latest effort of the writer. The changes, though comparatively few, will be found to increase the usefulness of the volume. Indeed, today as heretofore it will stand as a model of its kind. The keynote of the volume before us is practicalness, and the author by training is well fitted to make a book which is adapted to the purposes for which it is intended; namely, a book on the practice of gynecology as applied to the treatment of women's troubles in actual practice. As in former editions, so here, the illustrations are numerous and excellently executed, true to nature and helpful. Among the noteworthy changes are a modernization of the chapters on hematology as it affects surgery; the treatment of syphilis by salvarsan, treatment of cystitis, appendectomy; the use of tincture of iodine as an antiseptic in sterilizing the skin for an operation, and alterations in the technic of many of the operations. Among the new material are chapters on the use of Coley's mixed toxin in inoperable sarcoma of the genito-urinary tract, actinomycosis of the uterine adnexa, Krunkenberg's tumor and pseudomucinous cyst-adenoma, the Fowler-Murphy method of treating suppurative peritonitis and a number of other subjects of equal interest.

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Diseases of the Mouth. For Physicians, Dentists, Medical and Dental Students. By Professor Dr. F. Zinsser, Director of the Department of Dermatology at the City Hospital, Lindenburg; Dozent at the Academy for Practical Medicine, Cologne. Translated and edited by John Bethune Stein, M.D., Professor of Physiology at the New York College of Dentistry; Late Instructor in Genito-Urinary Diseases at the College of Physicians and Surgeons (Medical Department of Columbia University), New York City. With 52 colored and 21 black-and-white illustrations. New York: Rebman Company. Cloth, $7 net. 1912.

This book should, and no doubt will, exert a powerful influence in directing attention to diseases of the buccal cavity, a subject which hitherto has been woefully neglected. Through a complete exposition of the subject, augmented by a pictorial review, the reader is fully apprised of the various diseases of the mouth and their clinical appearances. This is a very effectual method of driving home a lesson, but one, indeed, only too frequently neglected. This feature alone makes the book very valuable to physicians when dealing with obscure lesions of the oral cavity. With unusual clearness the author lays before us the picture of oral diseases and most graphically outlines their differential diagnoses. The translator is to be congratulated not only upon the excellence of his rendition of the original into English, but also upon his foresight in supplying such a needed link in the English literature.

# MARYLAND MEDICAL JOURNAL

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BALTIMORE, JANUARY, 1913


## INTERFERENCE OF LAY PUBLICATIONS IN MATTERS MEDICAL.

EVERYONE with any intelligence at all thoroughly realizes the tremendous influence which the lay press (newspapers and popular weeklies and monthlies) exerts in shaping and influencing popular thought. As a matter of fact, it is the only avenue of information through which a large majority of the population become familiarized with the events of the day. It is therefore plainly the duty of editors of such publications to be extremely careful and discerning when they give out medical information, as many times more harm than good may result. Editors must realize that they are alike judge, jury and court-of-last-resort, which threefold office renders it incumbent upon them that before issuing statements on scientific and medical matters they should be absolutely sure of the ground upon which they are treading, as the setting aright of a statement but partially understood or totally misunderstood is no easy matter, and is ofttimes impossible of accomplishment.

Thus the profession loses valuable time. The habit of employing a layman to write upon medical achievements and methods is especially pernicious, as the physician is a very peculiar compound, and does not relish interference in his affairs from such a source. When a publishing firm wishes to give publicity to recent discoveries it should first obtain the permission of the discoverer or the man who has done the greatest amount of work in that particular line; and, at any rate, should see that the article is prepared and sanctioned by a number of reputable physicians. In this way, and this way alone, can a firm be sure it is giving out correct data and is not doing actual harm. Otherwise it puts in the hands of the public a weapon against the profession which can be used to its disadvantage. It is the easiest thing in the world for some self-opinionated layman to insist that his own diagnosis of his disease was correct, and to insist upon a use of the "marvelous discovery" of which he had read in a "thoroughly reputable" magazine, and to

find the doctor who would use the remedy in order not to lose the patient; and the result is always that the method of treatment suffers, both in the minds of the public and the profession.

The occasion of these remarks is the appearance in the January issue of Pearson's Magazine of an article on the Schafer Phylacogens, by Arno Dosch. As is well known by the profession, the status of these preparations is not as yet out of the experimental stage, and before they are finally accepted as of definite value much more experimental work with them will have to be performed. Undoubtedly, many cures of rheumatism and arthrites from their use have been and are being recorded; still, their exact place in our therapeutic armentarium has not been definitely decided. Being a member of the profession and well aware of its antipathy toward the exploitation of remedies of any character whatsoever in the lay press to readers-at-large, especially before their true value is thoroughly known, we consider that such methods as employed by Pearson's will hamper rather than advance the introduction of scientific advances.

The persons most interested have appealed in vain to Pearson's, but vehement protest has been without avail. The possible antagonism which may be aroused in the medical fraternity by the appearance of such an article in such a place has been pointed out to them, but it has been useless. The only place a lay journal has in medical matters is in teaching hygienic lessons, and such simple lessons as those of first aid; but self-medication or the exploitation of anything which may be misconstrued as a specific for any ill, no matter how slight or how serious, cannot be condemned too severely. It leaves in the hands of the public too poignant a weapon against the medical profession. From a careful perusal of the correspondence in the matter we believe that the editor of Pearson's is not intentionally working an injury to the medical profession, but is either misguided by bad advisers or is sadly mistaken in his judgment concerning the advisability of such an article. He is apparently sincere in his belief that his publication will be conferring upon suffering humanity a ray of hope of deliverance from their afflictions, and is therefore justified in the publication of this article. We are extremely sorry he has taken this view, and believe he has delayed the general acceptance of a good treatment; but in justice to him, he is in no wise the worst sinner among lay editors in this regard, for some of the simple hygienic measures we have seen advocated in one of our most widely-circulated monthlies would put an Indian herb doctor to shame.

# Medical Items.

THE Board of Medical Examiners of Maryland has incorporated in their record this expression of appreciation of the character and services of our fellow-member, Dr. Franklin Buchanan Smith, who has been called hence.

"Dr. Smith was one of the original members in the organization of this board, having been elected by the faculty in 1892, and was present at the first meeting held June 2, 1892. His successive re-elections indicate the value of his services as a member of the board and his sympathy with the effort to advance the standard of medical education and promote the higher and better interests of the profession. Our relations with our esteemed associate confirm this estimate of his work and worth.

"In his death the medical profession has lost a member whose constant effort was toward higher ideals, a greater efficiency and a nobler consecration of self to service; this board, a member always helpful and animated by conscientious purpose; the State, a citizen whose activity and participation in public affairs was always in the direction of the uplift and advancement of the community of which he was a respected and honored member.

"To the distressed family of our brother we extend our sincere and heartfelt sympathy, and the secretary is directed to publish this minute in the *Bulletin,* the MARYLAND MEDICAL JOURNAL, and transmit a copy to the widow of our deceased brother."

THE property of the Pine Bluff Sanitarium, located on the Wicomico River, has been purchased for use as a State institution for the care of incurable cases of consumption. The property comprises about 20 acres of land. There is upon it a main building, and the entire tract, except one acre surrounding the building, is covered with a dense growth of pine trees. The board has selected Dr. George W. Todd of Salisbury, a graduate of the University of Maryland in 1885, as superintendent of the new institution, and the institution will be ready to receive patients January 1.

DR. HAMPSON H. BIEDLER, who has been quite ill with pneumonia, is reported to be convalescing rapidly.

DRS. FRANCIS E. HARRINGTON of Cumberland and James C. Holdsworth of Eckhart Mines, Md., are suffering with smallpox, contracted from patients suffering with the disease. Miss Myrtle Clark, a nurse in the Western Maryland Hospital, is also suffering with a light case.

THE following officers were elected by the Southern Surgical and Gynecological Society at its annual meeting, held in Newport News, Virginia:

President—Dr. John Young Brown, St. Louis.

First Vice-President—Dr. F. Morgan Vance, Louisville, Ky.

Second Vice-President—Dr. Lomax Gwathney, Norfolk, Va.

Secretary—Dr. W. D. Haggard, Nashville, Tennessee.

Treasurer—Dr. Le Grande Guerry, Columbia, S. C.

Dr. Floyd McRae of Atlanta was named chairman of the committee on arrangements for the next meeting.

Atlanta, Ga., has been selected as the next meeting place.

DR. RICHARD C. MASSENBURG is seriously ill at his home in Towson. Dr. Massenburg is Health Officer of the Ninth District. During the Civil War he served in the Confederate Army. He was for many years secretary of the Baltimore County Medical Association.

DR. RALPH B. SEEM has assumed his duties as an assistant superintendent at the Johns Hopkins Hospital. He is a graduate of Lafayette College, of the class of 1902, and of the Johns Hopkins Medical School in 1906. He was resident physician of St. Luke's Hospital, South Bethlehem, Pa., for two years, and then superintendent of the James Walker Memorial Hospital at Wilmington, N. C., for three years before coming to Hopkins.

THE Allegheny Hospital of the Sisters of Charity was opened for inspection on December 9. It has accommodations for 100 patients.

DR. GEORGE C. WEGEFARTH was operated on for appendicitis December 12 at the Church Home and Infirmary.

DR. JOHN ARTHUR F. PFEIFFER, 1112 North Stricker street, has returned from a trip abroad.

DRS. J. LEE HOPKINS of Havre de Grace, Md., and Louis A. Monmonier of the Green

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## SHARP & DOHME

***The Hypodermic Tablet People***

**BALTIMORE, MD.**

Spring Valley, suffered serious losses by fire during the past month.

Dr. Philip B. Housekeeper of Northeast, Md., is critically ill in the German Hospital, Philadelphia.

Dr. Andrew Watson Sellards of the Johns Hopkins Hospital has gone to Turkey to assist in the American National Red Cross Society's fight against cholera.

Dr. Thomas B. Johnson of Frederick, Md., is suffering considerable pain from a badly swollen and bruised face, due to an assault made upon him by Harry Buch, an agitator, whom Dr. Johnson spoke to in reference to an overdue account.

The Baltimore Medical Society has issued a letter to each member, requesting aid in suppressing the "free advertising" of physicians and their accomplishments in newspapers, and requests physicians to report each violation of the ethical rule.

The Calvert County Medical Association has elected the following officers for the ensuing year: President, Dr. Oliver D. Simmons of Bowens; vice-president, Dr. George Peterson of Wallville; secretary-treasurer, Dr. John W. Leitch of Huntington, and censor, Dr. Isaac Newton King of Barstow, Md.

The famous Flint Club held its annual meeting in the Rennert Hotel, Baltimore, on December 5, 1912. Dr. J. H. Branham was toastmaster, and among the speakers were Drs. John D. Blake, Charles G. Hill, William Caspari and Richard Johnson. The druggists' Wedgewood Club was at the same time holding its annual meeting in the adjoining room, and the two clubs exchanged greetings.

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### MARRIAGES.

John Charles Norton, M.D., University of Maryland, '12, of Hagerstown, Md., to Miss Ruth Cleveland Atkinson of Baltimore, at Baltimore, December 3, 1912.

Franklin Webb Griffith, M.D., Johns Hopkins Medical School, '06, of Asheville, N. C., to Miss Grace Howlett Lemmon, Johns Hopkins Training School for Nurses, '08, of Baltimore, Md., at Baltimore, December 26, 1912.

Michael Albert Abrams, M.D., College of Physicians and Surgeons, '09, of 1634 E. Baltimore street, Baltimore, to Miss Marie Silberstein, also of Baltimore, November 28, 1912.

Carl Voegtlin, M.D., Johns Hopkins Medical School, of Baltimore, Md., to Miss Lillian Kreuter of New York, at New York, December 21, 1912.

Frank Sidle Lynn, M.D., University of Maryland, '07, of 1619 St. Paul street, Baltimore, to Miss Clyde C. Dawson of Griston, N. C., at Norfolk, Va., on Saturday, December 14, 1912.

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### DEATHS.

Arthur McCabe, M.D., Baltimore University, '97, Queen's University, Ontario, '03, died at his home in Gloucester, Mass., November 12, 1912, aged 45 years.

William A. Dorsey, M.D., College of Physicians and Surgeons, '05, formerly resident physician at Mercy Hospital, Baltimore, was instantly killed on December 17, 1912, by contact with a live wire. Dr. Dorsey was returning from a visit to a patient, and the wires had been blown down by a storm, and he was unable to see them because of the darkness.

Lemuel S. Lawson, M.D., University of Maryland, '67, died at his home in Dallastown, Pa., December 5, 1912, from uremia, aged 75 years.

William Samuel Love, M.D., University of Pennsylvania, '61, died at his home in Winchester, Va., December 12, 1912, aged 76 years.

Michael Joseph Gately, M.D., Georgetown University School of Medicine, '72, died at his home, 111 S. Broadway, Baltimore, December 16, 1912, of apoplexy, aged 65 years.

Alfred B. Giles, M.D., University of Maryland, '80, of 3703 Forest Park avenue, Baltimore, died at his home December 21, 1912, of heart trouble, aged 50 years.

William Hand Browne, M.D., University of Maryland, '50, professor emeritus of English literature in the Johns Hopkins University, died at his home at Sherwood, Md., December 12, 1912, after an illness of one week, of chronic bronchitis, aged 84 years.

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# COXALGIA AND CHRONIC APPENDICITIS WITH ADHESIONS.

*By Thomas R. Brown, M.D.,*
Baltimore, Md.

Associate in Medicine, Johns Hopkins University.

I THOUGHT it might be of interest to call attention very briefly to one of the interesting and yet little-studied sides of appendicitis, coxalgia—*i. e.*, pain—usually increased by movement of the right hip. I shall not refer here to that met with in the acute forms of the disease, for here, as a rule, the other clinical symptoms are so definite that the diagnosis is comparatively simple. Nevertheless, in a few of the adult cases and in many of the cases in children the symptoms are often so vague and the diagnosis so extremely difficult that we frequently derive considerable diagnostic help by noting the pain in the right hip, by seeing that the patient constantly keeps the right hip well flexed, or by the increased pain in that hip produced by forcible extension. The cases I refer to offer much greater difficulties in diagnosis; they are the cases of chronic appendicitis, with no or very slight local symptoms, where the diagnosis is only possible by the correlation of many little signs and symptoms, each of comparatively slight importance in itself. Of these, one of real value is the definite coxalgia met with in a certain proportion of these cases. The nature and extent of the various symptoms met with depends somewhat upon the pathological process in the appendix, whether it is due to adhesions, obliteration of the lumen, cysts, erosions, torpid ulcers or fecal calculi, but far more to the direction in which the appendix points—toward the gall-bladder, toward the urinary bladder, or toward the thigh—to the number and thickness of the adhesions, and to the association of the disease with a splanchnoptosis of considerable grade, a very common occurrence in our experience. Thus in one group there may be no local symptoms

whatsoever, and the picture presented may be typical of a psychoneurasthenia, with its general complaints, or may be that of a typical gastric or intestinal dyspepsia, or may simulate cholelithiasis, or cholecystitis, or may present as the main symptoms pain in the right hip, or pain on urination, often a combination of both.

In a series of 20 cases of chronic appendicitis diagnosed beforehand as such, and verified by the operation, in three the main symptom was pain in the right hip, coxalgia appendiculaire; in one the pain had been so intense, was so definitely related to exertion, and had extended over so long a period of time, that a chronic tuberculous coxitis had been seriously considered. Incidentally each of these three cases was associated with splanchnoptosis of the highest grade, and showed dense adhesions, binding appendix, cecum, and a portion of the transverse colon tightly down to the lateral abdominal wall and to the pelvic floor.

Two questions arise in these cases: first, without local symptoms in the appendical region, what aids have we in reaching a correct diagnosis in addition to this pain in the right hip, which is often absent altogether and sometimes absent when the patient is at rest, but is noted after walking, and increased by a flexion of the joint; and, second, how can this condition be differentiated from a chronic tuberculous infection of the hip joint of a very latent nature? In answering these two questions we have been much helped, in the first place, by most careful temperature observations, taken at frequent intervals at rest and after exercise, some slight temperature being very usual in chronic appendicitis and in tuberculosis of the hip, especially after exercise, sometimes a continuous slight fever, more often a mildly remittent type, rarely reaching 100, while a careful study of X-ray plates at various intervals of time after the administration of bismuth, and which were beautifully made by Dr. Baetjer in most of our cases, is of paramount importance, showing in these cases the tight binding down of this portion of the intestinal tract, with very sluggish motility and marked bismuth retention, the hip joint being entirely normal.

In differentiating chronic appendicitis from tuberculous disease, and also as an aid in diagnosing the condition, the determination of both the absolute and differential leucocyte counts is really of great importance—a leucocytosis of from 10,000 to 16,000, though rarely over 13,000, with neutrophiles from 75% to 85%, speaking, of course, for chronic appendicitis—a leucopenia with relative mononuclear increase for tuberculosis. Rovsing's sign, that pressure on the descending colon produces pain in the appendix region, and "la tâche appendiculaire" of the French—the white vertical line on either side of the mouth, with red, rather hectic, cheeks—we have found of slight value.

One case was especially interesting in this connection in which the pain in the hip was so marked that several surgeons who saw

the case regarded it as probably due to a coxalgia secondary to relaxation of the sacro-iliac joint. Nevertheless, a most thorough examination of the patient by Dr. Baer showed no trouble with the joint whatsoever, while the result of the X-ray examination by Dr. Baetjer and the operation by Dr. Fisher showed beyond question that this pain was referable to the dense adhesions in the appendical region, binding down appendix, cecum and ascending colon tightly to the lateral and posterior peritoneal surfaces, and probably definitely affecting either certain nerves themselves or their blood supply. We append the X-ray findings of Dr. Baetjer and Dr. Fisher's note on the operation findings.

DR. BAETJER'S NOTE.

"Eighteen-hour plate—Dilated cecum and ascending colon, with prolapse and enlargement of the transverse colon. Stomach vertical, somewhat prolapsed.

"Forty-two-hour plate—Retention of bismuth in cecum and at hepatic flexure.

"*Conclusions.*—Retention in cecum and ascending colon; sluggish colon."

DR. FISHER'S NOTE ON THE OPERATION.

"Abdomen opened through the right rectus incision; cecum more tightly fixed to posterior abdominal wall than usual. Following the anterior longitudinal band of the colon to its termination failed to reveal the appendix. After dividing the adhesions over the head of the cecum, the base of the appendix was found closely adherent to the cecal wall. The direction of the appendix was posterior to the cecum, the tip being found over the pelvic brim. The appendix was densely adherent throughout its whole extent, the tip being acutely flexed and bulbous. The ileum in its last three inches was partially knicked by a band of adhesions, drawing it posteriorly and toward the cecum. The appendix was removed in the usual manner, the adhesions about the ileum released, and the resulting raw surface covered as far as it was possible to do so without reproducing the kink in the ileum. Wound closed without drainage. Digital palpation failed to demonstrate any lesion in pelvis or in region of the gall-bladder and duodenum."

One very interesting point in this connection is the very frequent association of these cases of chronic appendicitis without definite local symptoms, with splanchnoptosis or general descensus of the abdominal viscera. In our series of 20 cases, each verified by subsequent operation, in considerably more than half a greater or less degree of descensus of the abdominal organs was met with, in many of these cases of a very high degree, so that the cecum and a large portion of the transverse colon were found entirely

below the pelvic brim. It is difficult to say whether the chronic appendicitis is primary, whether it is due to the ptosis of the intestines, with its associated disturbance in the blood and lymph supply, and its tendency to produce sluggish motility and fecal retention in the ileo-cecal region, or whether, due to this retention and accumulation, a local peritonitis is produced, due to bacterial migration through the lymphatics and the blood vessels, and that the appendix is simply involved in this process and is bound down by the adhesions formed by this mild, local, inflammatory process. Certainly most cases of marked ptosis in the ileo-cecal region in time come to fixation by adhesions to a greater or less extent to the posterior, lateral or inferior peritoneal surfaces.

From the study of these 20 cases, all verified by operation, in three of which the coxalgia was the predominant symptom, while in many others it was present, but did not dominate the picture, we think we are quite justified in concluding that coxalgia is quite often met with as a part of the picture of chronic appendicitis, a disease in which the symptoms may be so vague or so definitely referred to some other organ in the abdominal cavity that a diagnosis is very difficult to reach. In a few cases a definite, severe and persistent coxalgia may be the most striking feature of the case and may help us in reaching a diagnosis. From an appreciation of this fact, from a careful study of the temperature, at rest and after exercise, and of the leucocytes, both the absolute number and the percentage of the various forms, and a careful study of the X-ray photographs and repeated fluroscopic examinations, a diagnosis may be reached which would otherwise be impossible. Certainly all cases of coxalgia of a mild form, especially if associated with ptosis of the abdominal viscera, should make us consider chronic appendicitis with ileo-cecal adhesions as a possible cause, and should lead us to especial investigations along the lines mentioned above. As to the cause of this pain, it is conceivable that it might be due to mechanical, or it might be due to chemical causes. We have reported elsewhere a long series of cases of myalgia, neuralgia and neuritis, secondary to a disturbed metabolism, possibly that associated with the so-called arthritic diathesis of the French, characterized by a marked increase in the acidity of the urine and markedly benefited by the administration of alkalies in large amounts, but in these cases of right-sided coxalgia it seems far more probable that the pain is not due to circulating toxins, due to the fecal retention and the abnormal permeability of the blood and lymph vessels in the adherent loops of intestine, but is based on anatomical grounds, and is due to the mechanical effect of the dense adhesions. The direction in which the appendix points and the nature, extent and position of the adhesions seem to be the determining factors in deciding whether in the individual case coxalgia is or is not to be met with.

# THE BINET-SIMON SCALE AND ITS VALUE TO THE CHILD.*

*By Wm. Rush Dunton, Jr., B.S., M.A., M.D.,*
Assistant Physician, Sheppard and Enoch Pratt Hospital.

It seems hardly worth while to go into any detailed description of this scale, and it will perhaps be sufficient to say that it consists of a number of graduated tests so arranged that we can quickly learn the mental age of the child under examination.

Certain modifications in this scale have been made by Dr. Henry H. Goddard of Vineland, which are at the present time used by most of those using this test in this country.

Ordinarily, defective children having a mental age below two years are graded as an idiot, and those having a mental age between two and seven years as an imbecile. Those having a mental age between seven and twelve years are graded as morons. Frequently the pathological condition causing the defectiveness may be used in addition, such as an hydrocephalic idiot, and certain other descriptive terms are also used.

At the Psychiatric Clinic of the Johns Hopkins Hospital Dr. Edward B. Huey has been using this test for over a year, and has examined children sent by school authorities or by the Federated Charities, or anyone who has a suspicion that the child may be defective, which is keeping him from satisfactory study.

I have become acquainted with this test, and when Dr. Huey or his assistants have not been present have made these tests myself, so that I am gradually acquiring some familiarity with them, and at present am more or less competent to decide as to the exact mental age of the subject. Previous to using this test it was much more difficult for me to give the mental age of a child, and its use makes the examination briefer and much more accurate.

It is through the familiarity with this test that I have become so convinced as to its value to the child.

We can easily conceive how difficult it is for certain children to keep up with their studies and to carry on tasks for which they are mentally unfitted. We have probably—and unfortunately—seen this occur over and over again. If the child is examined with these tests, such mental strain is less likely to occur, and I have previously advocated the establishment of a psychologist or someone educated to carry out these tests in every school. At present I know of but one school in Baltimore where such a test is made upon each pupil, and that is the Park School.

It will be very easy to go into this subject at much greater length, but it seems hardly worth while, as we can see what is really necessary in a very short time.

It is the experience of alienists that very many cases of dementia praecox have been caused, at least partly if not entirely,

*Abstract of remarks made at a meeting of the Baltimore County Medical Association, November 21, 1912.

by mental overwork. It is as easy for us to conceive of a person spraining their brain as it is to sprain any other part of the body. If this test is applied to all children and their mental status is determined, they can be directed into paths of usefulness and occupation which will serve to render mental strain practically impossible. We would, therefore, have fewer defectives to care for.

Through the co-operation of the School Board of Baltimore a special class for these defective children, who have been tested by the Binet scale, will shortly be established, and it is probable that it will be productive of good results.

The Psychiatric Clinic will be very glad to co-operate with any of you gentlemen who may know of children who are not doing well at school, and will be glad to make examinations to determine their mental status and help the teacher to better form an opinion as to the trouble with the child, so that anyone sending a child for examination to the clinic will be sure that it will receive proper attention.

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VACCINE THERAPY. Its Theory and Practice. By R. W. Allen, M.D., B.S. (Lond.), Late Clinical Pathologist to the Mount Vernon Hospital for Disease of the Chest; Late Pathologist to the Royal Eye Hospital; Late Gull Student of Pathology, Guy's Hospital. Fourth edition. Philadelphia: P. Blakiston's Son & Co. 1913. Cloth, $3 net.

Vaccine therapy has today become so thoroughly fixed as a live therapeutic agent, and its uses are being so constantly extended into new fields, that a résumé of the subject at this time is indeed timely. Such marvelous results have been obtained by this method of treatment that physicians, as a whole, are constantly calling one vaccine or the other to their aid. Of late rapid strides have been made in this field of therapeutics, but the literature is in so scattered a form that it is inaccessible to the majority of practitioners, therefore a work of this character which brings the subject up to date should be welcome to the host of physicians who are employing vaccine treatment. The book, which deals with the antibodies, their nature, source and functions; the value of opsonic index estimations in diagnosis, prognosis and treatment; the vaccine, its method of administration and preparation; the rationale of vaccine treatment and some causes of failure; diseases of the skin and the subcutaneous tisues, diseases of bones and joints; diseases of the digestive tract, diseases of the genito-urinary system, diseases of the circulatory system, etc., contains the latest ideas concerning this important subject, and gives minute directions as to the uses, methods of preparation and physiological action of the several vaccines. It is a book that the general practitioner cannot well be without, and should be upon every physician's bookshelf.

# HERNIAS OF THE OVIDUCT, OVARY AND OVIDUCT AND OVARY

*By Aimé Paul Heineck, M.D.,*

Surgeon to the Jefferson Park Hospital, to the Grace Hospital and to the Cook County Hospital, Chicago. Professor of Surgery, Bennett Medical College, Loyola University.

(*Continued from January issue.*)

## POST-OPERATIVE VENTRAL HERNIAS OR HERNIAS IN ABDOMINIAL SCARS.

The protrusion of parietal peritoneum with stretching of the cicatrix over it may occur after any operative or other penetrating wound of the abdominal wall, except those of very small dimensions.

Though these hernias may occur in any part of the abdominal wall, they are located almost always either in the median line or in the region of the appendix. Owing to the employment of improved operative technique, and to the more rigid observance of the requirements of surgical asepsis, post-operative hernias are decreasing in frequency.

There are two types: In one there is a uniform distention of the cicatricial tissue producing a condition somewhat analogous to separation of the recti muscles; in the other the hernia is due to the giving way of weaker portions of the scar.

The main predisposing etiological factors of post-operative hernias are: (1) Long incisions; (2) faulty closure of abdominal wounds; (3) operations for suppurative processes, which of themselves require for healing that the abdominal wound be maintained open for a considerable period of time; (4) drainage; (5) disturbed wound healing—imperfect asepsis—suppuration; (6) failure to wear for some months after recovery from operation a well-fitting abdominal binder; (7) too early pressure upon the scar; (8) pregnancy.

The only ventral hernia of the uterine appendages which we could find is a tubo-ovarian hernia in an abdominal scar resulting from the opening and prolonged drainage 10 years previously of an appendiceal abscess. The scar was about six inches in length. Cullen, to cure this case, resected the entire cicatrix, loosened the adhesions of the omentum to the ovary; then removed the herniated ovary and hydro-salpinx, and followed this by closure of the abdominal wound without drainage. A satisfactory recovery was obtained. The sac was incomplete for a considerable distance; the ovary lay directly beneath the skin.

*Gluteal, Sciatic or Ischiadic Hernias.*—This is a very uncommon condition; in the medical literature of the last 150 years only 23 cases are recorded (E. Koeppl). This class of hernias escapes from the abdominal cavity by way of either the greater or the lesser sacro-sciatic foramen. There are three varieties, the supra-

pyriformis, the infra-pyriformis and the spino-tuberosa. These hernias may be congenital or acquired; may occur on either side of the body, and are subject to all the complications of hernia in general. Thirteen of the cases on record were observed in women. Schilbach's case is the only one on record making its exit through the lesser sacro-sciatic foramen. The diagnosis was first made at the autopsy table. During life there had been genital hemorrhage and symptoms of ileus. At the post-mortem examination the ovary was found in the hernial sac, the tube and the broad ligament being caught in the hernial ring.

We found only two cases of ischiadic hernia of the uterine appendages. Both were acquired hernias of the right tube and ovary, occurring in multiparous patients. Both were subjected to operation and recovered.

Woelfler's case is interesting in that it was successfully subjected to an operation for radical cure. The hernia, an infra-pyriformis one, emerged like all others of its type, along the lower border of the pyriformis muscle in close relation to the internal pudic, inferior gluteal and sciatic nerves and vessels. For the previous two years the patient had had attacks of pain radiating along the course of the sciatic nerve, and abdominal suffering associated with nausea and, at times, vomiting. In the right gluteal region there could be palpated below the muscles a globular, fluctuating, fist-sized, non-reducible swelling, from which at one time there was removed by aspiration 50 cubic centimeters, and at another time 500 cubic centimeters of dark reddish fluid containing much albumen, red blood corpuscles and leucin-tyrosin crystals.

The following operation was performed: An eight-centimeter long incision, parallel to the course of the fibres of the gluteus maximus, was made over the summit of the hernial swelling. The muscle fibres were separated; the hernial sac exposed, isolated and opened. It contained the ovary and the end of the tube. The sac contents were ablated; the resulting stump reduced in the abdominal cavity. The sac was then ligated and cut off, after which the operator closed the hernial orifice by approximating the pyriformis muscle to the lesser sacro-sciatic ligament.

*Obturator Hernias.*—In obturator hernias, the herniated viscus or viscera always escape from the abdominal cavity by way of the obturator or subpubic canal. These hernias, though less infrequent than ischiadic hernias, are nevertheless uncommon; not more than 200 cases are recorded in the medical literature. They are usually small; may be unilateral or bilateral (are more frequent on the right side); may co-exist with hernias of a different type. They may be reducible, irreducible or strangulated.

Picqué and Poirier recognize three main anatomical varieties of obturator hernia. In the first variety, the most common, the hernia follows the entire course of the obturator canal, appearing as a swelling in front of the external orifice of this canal. In the second variety the hernia escapes from the abdominal

cavity through the pelvic orifice of the subpubic canal, but following the course of the inferior division of the obturator nerve, does not traverse the canal's entire length, and makes its exit by passing between the superior and middle bundles of the obturator extermus muscle. In the third variety, the hernial protrusion also enters the pelvic orifice of the obturator canal, but becomes lodged between the obturator membrane and the obturator externus muscle.

Objective symptoms are frequently absent. When a swelling is visible and palpable, it is usually of small volume and is located in the most internal portion of Scarpa's triangle, somewhat resembling a femoral protrusion. It is, however, non-pediculated and does not extend in the direction of the crural canal. In suspected cases, one should always determine whether there is increased pain when the obturator externus is put under tension—abduction and rotation inward of the thigh.

Vaginal examination is important. The internal orifice of the subpubic canal is accessible to the vaginal hand. Two routes are advised for the treatment of obturator hernias, the abdominal route and the obturator route. In the obturator route, the following steps are employed:

1. An incision eight centimeters long is made about three and a half centimeters internal and parallel to the femoral artery.
2. Separate with a grooved sound the internal border of the pectineus muscle from the outer border of the abductor brevis and abductor longus muscles.
3. If necessary, divide a few of the fibres of the pectineus muscle close to their insertion on the pubic bone, so as to facilitate digital exploration of the obturator region.
4. Expose, isolate and open sac; determine its relation to the obturator nerve and vessels, after which nick constricting point if hernia be strangulated and reduce or ablate hernial contents.
5. Closure of wound.

*Femoral Hernias.*—Hernias which in their escape from the abdominal cavity pass between Poupart's ligament and the horizontal ramus of the pubis, and sooner or later protrude in Scarpa's triangle, are called femoral hernias. Common femoral hernias escape from the abdomen through an orifice bounded anteriorly by the most internal portion of Poupart's ligament; posteriorly by the horizontal ramus of the pubis; externally by the femoral vein and the sheath of the femoral vessels; internally by Gimbernat's ligament. They descend along the most internal compartment of the femoral sheath and ultimately emerge through the saphenous opening. These hernias are contiguous to the femoral vein which always lies external, and they carry along in their progress through the crural canal a mass of condensed areolar tissue, known as the septum crurale. They show a greater tendency to expand upward than downward because the cribri-

form fascia is less adherent to the upper margin of the saphenous opening.

The small number (16 cases) of femoral hernias which we were able to collect, as compared to inguinal hernias, confirms the now accepted but previously disputed fact that in the female inguinal hernias are of more frequent occurrence than femoral hernias. All these femoral hernias were of the acquired type; it is known that congenital femoral hernias are pathological rarities. A femoral hernia is essentially a hernia of adult life. Either side of the body may be involved. The tendency to double femoral hernia is less than that to double inguinal hernia. All femoral hernias, irrespective of contents or of sex of bearer, are of more frequent occurrence on the right side (Wernher, Macready, Berger).

The tubal hernias contained the oviduct either in part or in its entirety, alone or associated with intestine omentum, or both. The presence of the appendix vermiformis in a femoral hernial sac is rare. Coley states that in 2200 cases of hernia operated upon from 1890 to March, 1908, in the Hospital for Ruptured and Crippled, the appendix vermiformis alone was found in 10; the cecum and appendix together in 7. In not a single one of Coley's cases was the appendix found in a femoral hernial sac (W. B. Coley, Keen's Surgery, 1908, vol. I, page 78).

These hernias may be reducible, irreducible or strangulated. Strangulation can occur at any one of the following sites: (a) Internal femoral ring; (b) margin of Gimbernat's ligament; (c) margin of the saphenous opening; (d) meshes of the cribriform fascia; (e) irregularities in the hernial sac. The following operations were performed: (a) Amputation of fimbriated end of tube; (b) incision of hernial swelling and creation of an artificial anus; (c) ablation of tube; (d) ablation of ovary; (e) ablation of tube and ovary; (f) excision of hernial sac and return of tube to abdominal cavity; (g) removed tube and ovary and resected gangrenous intestine.

Truss treatment of femoral hernia is notoriously unsatisfactory and is considered as being only palliative and not at all curative. In femoral hernias, on account of motions of thigh, it is difficult to apply, and especially to maintain pad-pressure in a position conducive to closure of the hernial openings.

Coley, whose clinical experience with the treatment and cure of hernia is greater than that of any other living American surgeon, supplements to high ligation and ablation of the hernial sac with the thorough removal of all extra peritoneal fat the following step. He introduces a pursestring suture of kangaroo tendon in such a way as to bring the floor of the femoral canal in contact with the roof.

*Inguinal Hernias.*—Hernias which escape from the abdominal cavity, either through the internal or external inguinal fossae, and which emerge upon the surface when complete by way of the

external abdominal ring, are known as inguinal hernias. Of all hernias, they are the ones most frequently noted in the female.

Inguinal hernias of the uterine adnexae may be complete or incomplete. In the incomplete form, the hernia has not escaped beyond the external abdominal ring. Inguinal hernias may be right-sided or left-sided. They may be unilateral or bilateral; as previously stated, all the bilateral hernias of the uterine adnexae, tubal, ovarian or tubo-ovarian recorded in the medical literature of the last 20 years, were of the inguinal variety. They may be reducible or irreducible. They may be strangulated or the seat of torsion. This last accident has only been observed in congenital inguinal hernias, the contents of which were irreducible.

Of the uncommon types of inguinal hernias, only several could be found. There was one direct hernia. This, especially in the female, is an uncommon form. The main characteristics of direct hernias are that the protrusion takes place by way of the internal inguinal fossa; that the neck of the sac is always to the inner side of the deep epigastric vessels and, in the female, that the round ligament is distinct from and to the outer side of the sac. We found three interstitial, or intra-parietal, hernias. All the other inguinal hernias were of the ordinary type; that is, external or indirect or oblique. An ordinary or oblique inguinal hernia in its course through the inguinal canal (narrower in the female than in the male) is accompanied by the round ligaments; as it escapes from the external abdominal ring, it appears in the upper portion of the labium majus, in which it descends to a greater or less extent.

Inguinal hernias vary in size and in form. They may be almond-shaped, ovoid, sausage-shaped, pear-shaped, pyriform, globular or other forms too numerous to mention.

### SYMPTOMS AND DIAGNOSIS.

Hernias of the uterine appendages present all the symptoms common to hernias in general. In some hernias of slow and gradual development, owing to the absence of symptoms, not uncommonly the patient ignores that she has a rupture. Some cases do not give rise to any symptoms; some give rise to very slight disturbances; many remain painless until the appearance of the menses and thus are first recognized at about the age of puberty. Pain may be absent during the entire course of a slowly developing hernia. In other cases, the hernial swelling may be so small as to be completely overlooked by a careless observer. Inspection, palpation and percussion of the hernial regions are routine steps in the examination. After having demonstrated the presence of a hernia, the operator has to determine the type of hernia present and the nature of its contents. The existence of other malformations is to be ascertained, as they may be of such a nature as to partially justify the sacrifice of healthy herniated organs.

Clinicians usually do not experience any difficulty in diagnosing

a hernia; at times, they are in doubt as to the type of the hernia present in the case at hand. In fatty individuals, the exact position of the hernial neck is difficult to determine. Obturator hernias are rare, and are found internal to the femoral opening; in femoral hernias, the swelling is found to be almost, if not entirely, below a line extending from the anterior superior iliac spine to the pubic spine.

In the female, the tumor mass caused by a complete oblique inguinal hernia, even of a moderate size, will cause a swelling extending into the labium majus.

In some hernias of the uterine appendages, the patients complain of a feeling of weight and discomfort. The symptom "tenderness on pressure," we find frequently reported. Some of these hernias are painless; some are so painful as to interfere very much with the patients' well-being. Impulse on coughing is not infrequently noted. It is not, however, a constant symptom present; it may be absent. Menstrual disturbances are recorded.

If an oblique inguinal hernia be incomplete; that is, if it does not extend beyond the inguinal canal, it may be mistakenly diagnosed tumor of the round ligament, bubo, epiplocele or encysted hydrocele of the canal of Nuck. In tumors of the round ligament, epiploceles, encysted hydroceles of the canal of Nuck, a mistake in diagnosis is not very significant, as in all these conditions one must to obtain cure resort to operative treatment and to exposure of the inguinal canal.

### TREATMENT.

Six of the reported cases were either autopsy-table or dissecting-room discoveries. In some cases, the nature of the operative intervention is not stated. In the other cases, the operators after performing either a laparotomy or a herniotomy, disposed of the herniated organs either by reducing or removing them entirely, or by removing a part and reducing the remainder. In some cases, the reduction of the hernial contents necessitated a preliminary division or a dilatation of the hernial rings, internal or external. In 213 operated cases, the results are stated: Eleven deaths; 202 recoveries.

We advise that all hernias of the uterine appendages, irrespective of anatomical site or of size or of age of bearer, be subjected to an operation for radical cure: (a) If the hernia be irreducible; (b) if the hernia be strangulated; (c) if the pedicle of the herniated organ or organs be the seat of torsion. After the age of two years: (a) If the hernia be bilateral; (b) if other hernias be co-existent; (c) when hernia cannot be painlessly, completely and permanently kept reduced; (d) if organs other than the uterine appendages be also present in the same hernial sac; (e) if the wearing of a hernial truss causes pain or aggravates the symptoms; (f) if the patient has to be subjected to ether or chloroform anesthesia for the performance of an operation of election, double advantage can be taken of this anesthesia

and an operation for the radical cure of the hernia performed; (g) if patient is exposed to pregnancy.

Operation in uncomplicated hernias of the uterine adnexae is no more dangerous than the operation for the radical cure of other hernias. It has practically no mortality. Infants bear hernia operations remarkably well. Broca performed 450 operations on children under 15 years of age with but one death. The operation which has given the most universal satisfaction in the treatment of inguinal hernias is that devised by Bassini. It has the advantages of safety, simplicity and efficacy.

We advise operators to observe in their operations for inguinal hernia the following suggestions:

1. Always wear and have the assistants wear rubber gloves.

2. All ligatures and irremovable buried sutures should be of absorbable material.

3. Always divide the aponeurosis of the external oblique muscle to the extent sufficient to give a good exposure of the inguinal canal and of its contents.

4. Always make a high and careful dissection of the hernial sac from the surrounding tissues, and especially from the round ligament to which it is often quite intimately adherent.

5. Always open the sac and determine by direct inspection and palpation the nature and state of the hernial contents.

6. After reduction or ablation of the hernial contents the sac is to be transfixed and ligated as high as possible. Sac is then removed flush with the peritoneal cavity. So as to prevent the occurrence of peritoneal bulging at the internal ring, we are in the habit of anchoring or fixing the stump of the sac about two centimeters above this point.

7. Never sacrifice the round ligament; it is harmful to the statics of the uterus. Never transplant the round ligament; it is unnecessary. The round ligament is left undisturbed at the bottom of the wound, emerging at the lower angle of the latter; the internal oblique muscle is sutured to the shelving portion of Poupart's ligament; the divided margins of the external oblique aponeurosis are sutured and the skin incision closed. No drainage. After operation, no truss should be worn; a truss does not support the scar, it weakens it.

8. In the female, the internal and external abdominal rings can be closed without detriment to the patient. In direct inguinal hernias, ligation of the deep epigastric artery is at times unavoidable. In hernias of the uterine appendages, the operator must decide as to whether the hernial contents are to be returned to the abdominal cavity or whether they are to be removed.

As to the herniated tube, ovary or tube and ovary when normal, it goes without saying that they should be returned, irrespective of patient's age; if adherent to sac wall or to some hernial content, the adhesions are to be loosened or divided, and if the organ or organs do not show marked structural impairment

they are to be reduced. These organs, when herniated, should be removed, if they be the seat of (a) unavoidable or actual gangrene; (b) benign neoplastic disease; (c) malignant neoplastic disease; (d) voluminous cyst formation; (e) malformation or incomplete development; (f) suppurative inflammation; (g) hematoma or interstitial ovarian hemorrhage; (h) seat of tubal gestation previous or subsequent to rupture of fetal sac; (i) tuberculosis limited to or extending beyond the herniated organ; (j) distortion beyond recognition; (k) such pathological changes as prevent function.

SUMMARY.

1. The Fallopian tube, the ovary or the tube and ovary, in part or in their entirety, may be herniated.

2. The herniated tube, ovary or tube and ovary may be the sole content of the hernial sac, or there may be present as associated hernial contents one or two or more of the following structures or organs: Meckel's diverticulum, appendix vermiformis, omentum, urinary bladder, intestine (small or large), uterus.

3. Tubal, ovarian and tubo-ovarian hernias are congenital or acquired, unilateral or bilateral; exist alone or in association with one or more other hernias of the same or of dissimilar anatomical types, of the same or of dissimilar clinical characteristics.

4. These hernias, in a small proportion of cases, co-exist with malformations, underdevelopment or absence of other internal genitalia or of some external genitalia: Imperforate vagina, absence of vagina, atresia of tube, unilateral absence of tube, of ovary or of tube and ovary, absence of cervix uteri, rudimentary uterus, absence of uterus, etc.

5. In individuals having a hernia of a tube, an ovary or of a tube and ovary, pathological states of other internal genitalia or of some external genitalia may be present: Vaginitis, ovarian cystoma, uterine fibroid, uterine prolapse and other uterine displacements, etc.

6. These hernias may co-exist with pathological states of organs other than the internal or external genitalia: Chronic hydrocephalus, multiple stenosis of intestines, hydronephrosis, etc.; these co-existing pathological states having no relation of cause or effect to the hernial infirmity.

7. Congenital or acquired hernias of the tube, ovary or tube and ovary may develop at any period of life. These hernias have been observed in nulliparae, in primiparae and in multiparae. No age is exempt. No race is immune.

8. According to their anatomical site, hernias of the uterine appendages are designated as post-operative or ventral, gluteal, sciatic or ischiadic, obturator, femoral and inguinal.

9. The tube, the ovary or the tube and ovary may be present alone or in association with other organs in the sac of any variety of gluteal, obturator, femoral or inguinal hernias.

10. Clinically, these hernias are reducible, irreducible, non-

inflamed, inflamed, strangulated or their pedicle may be the seat of torsion.

11. Torsion of the pedicle of a herniated ovary or of a tube and ovary, an accident peculiar to, and not infrequent in, hernias of the uterine appendages, gives the same clinical symptoms and determines the same anatomical changes in the herniated organs as are observed in the strangulation of hernial contents at one or another or more points.

12. We were able to collect eight times as many hernias of the inguinal type as of all the other hernial types put together.

13. Tubal, ovarian and tubo-ovarian inguinal hernias are recent, old or recurrent; are direct, interstitial or intra-parietal, indirect or oblique. If indirect or oblique, they are either complete or incomplete. A few sliding hernias are on record.

14. All the bilateral tubal, ovarian or tubo-ovarian hernias recorded in the medical literature of the last 20 years were of the inguinal variety. In bilateral hernias, both hernias may or may not show the same degree of development; they may have appeared simultaneously or one may have appeared a shorter or longer time before the other. They may show similar or dissimilar clinical characteristics. When bilateral, one hernia may be irreducible and the other reducible.

15. All the hernias in which the complication "torsion of the pedicle" occurred were irreducible congenital inguinal hernias.

16. All the femoral tubal, ovarian or tubo-ovarian hernias recorded in the medical literature of the last 20 years were of the acquired type and appeared in advanced adult life. "Femoral hernia is essentially a hernia of adult life."

17. Hernias of the uterine appendages, in the absence of anomalies of the other internal genitalia or of the external genitalia, do not prevent conception, do not interfere with gestation, nor unfavorably influence parturition. Pregnancy can occur previous to, during and subsequent to the existence of hernias of this nature.

18. The etiology of hernias of the uterine appendages is that of hernia in general. As main factors should be cited: All conditions that weaken the abdominal wall; all conditions that increase the intra-abdominal pressure, and all conditions that increase the mobility of the uterine adnexae. Heredity, pregnancy and the partial or complete persistence of the canal of Nuck are the most important causes.

19. The herniated organ or organs may be free from all degenerative changes.

20. The herniated organ or organs may be bound to the sac wall or to each other; may be the seat of congestion, gangrene, hemorrhage, inflammation, suppuration, tuberculosis (primary or secondary), cystic and neoplastic disease (benign or malignant).

21. The herniated organ may be the seat of gestation.

22. The hernial sac and the herniated adnexa or adnexae may be the seat of an inflammation, suppuration or other in character, which, in progressing by continuity of surface, has extended upward from the vagina, giving us the following anatomical picture: Vaginitis, endocervicitis, endometritis, salpingitis or pyosalpinx, ovaritis and saccular peritonitis.

23. The hernial sac and the herniated contents may be the seat of an inflammation, suppurative or other in character, which has reached the tube and ovary by way of the parametrial and parasalpingeal connective tissue.

24. Pathological processes originating in the hernial contents may by extension by contiguity of tissue involve the sac and its overlying tissues.

25. The hernial sac and the herniated tube, ovary or tube and ovary can become the seat of pathological processes secondary to disease of the associated hernial contents: Epiploitis, appendicitis, gangrenous gut, etc., infection spreading by contiguity of surfaces.

26. The herniated tube, ovary or tube and ovary and the associated hernial contents may be free of disease, or the uterine adnexae may be normal and pathological changes be present in the associated hernial contents: Appendicitis, gangrenous gut, epiploitis, etc. The associated hernial contents may be normal and the herniated uterine adnexae be the seat of morbid changes.

27. It is at times difficult, at times impossible, to state with absolute precision whether the anatomical changes present in the herniated organ or organs developed previous to or subsequent to the displacement of the tube, ovary or tube and ovary into the hernial sac.

28. Truss treatment for hernias of the uterine adnexae is not curative, is often productive of discomfort and interferes with the nutrition and development of the herniated tube or ovary.

29. Women suffering from any form of hernia should be carefully watched before, during and after their confinement, so as to prevent, or rather minimize, any undue strain upon weak regions of the abdominal wall. These women, at the close of lactation or toward the end of the first year following their confinement should, in the absence of contra-indications, be subjected to an operation for radical cure of the hernia.

30. In the female, all hernias, irrespective of anatomical site, of clinical condition or of nature of contents, should, in the absence of a constitutional state contra-indicating operations of election, be subjected to an operation for radical cure.

31. Clinical conditions so closely simulating hernias of the uterine appendages that a positive diagnosis without operation appears impossible, should be subjected to operative treatment. Only benefit can be derived from adherence to this rule. A diagnosis is established and a cure is effected.

32. In these hernias, as in all other hernias, the ideal time for

operation is previous to the development of degenerative or other pathological conditions in the herniated organ or organs and previous to the occurrence of any of the various complications incident to hernias.

33. The mortality of operation for the radical cure of hernias, if performed at an opportune time and by a rapid operator competently assisted, is nil.

34. To be effective, operations for radical cure of hernias must well fulfill two essentials: The suppression of the sac and the strengthening of the area through which the hernia has escaped.

35. In all herniotomies, the sac should be incised and the hernial contents examined.

36. In the female, the inguinal rings are comparatively small. They can, without inconvenience to the patient, be closed.

37. The herniated normal tube or ovary should never be sacrificed. These organs have an important role and in the absence of marked structural impairment should be returned to the abdominal cavity.

38. The herniated abnormal tube, abnormal ovary or abnormal tube and ovary should be removed if their return to the abdominal cavity is associated with peril, immediate or remote, to the patient or if these organs are so altered anatomically as to be functionally worthless. In sacrificing tissues or organs, the surgeon must be economical.

39. Until we are better informed as to the frequency and nature of true and false hermaphroditism, removed herniated uterine adnexae not having a distinctive structure should be subjected to a microscopical examination. This will avoid mistaking testicular for ovarian tissue and vice versa.

40. In the treatment of strangulated sciatic or gluteal, obturator and femoral hernias of the uterine appendages, in which the hernial sac also contains gangrenous gut, a double operation is almost always indicated: a laparotomy for the repair of the intestinal lesions and a herniotomy for the radical cure of the hernia.

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A COMPEND OF HISTOLOGY. By Henry Erdman Radasch, M.Sc., M.D., Assistant Professor of Histology and Embryology in the Jefferson Medical College. Third edition. Enlarged and revised, with 111 illustrations. Philadelphia: P. Blakiston's Son and Company. 1912. Cloth, $1.25 net.

The present edition of Radasch's "Compend of Histology" is so full that it would be more fitting to designate it "A Manual of Histology." However, as the value of a book is not measured by its name, but by its contents, for which reason it gives us great pleasure in recommending the present volume to the medical students of the United States. They will find it sufficiently fulsome for their purposes, absolutely trustworthy and an accurate adjuvant to their lectures, and extremely handy in preparing for State board and other examinations.

# Book Reviews.

INTERNATIONAL CLINICS. A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene and Other Topics of Interest to Students and Practitioners. By Leading Members of the Medical Profession Throughout the World. Edited by Henry W. Cattell, A.M., M.D., Philadelphia, U. S. A. Volume LV. Twenty-second Series. Philadelphia and London: J. B. Lippincott Company. Cloth, $2 net.

In the present number of International Clinics the following articles will be found of particular interest to the physician: "Parathyroid Treatment of Paralysis Agitans," "The Treatment of Diabetes," "Some of the Clinical Phenomena Associated with Arteriosclerosis, Enucleation of the Tonsils and Removal of the Adenoids and of the Lingual Tonsil by Simple Methods," "A Case of Stab Wound of the Heart; Transdiaphragmatic Pericardiotomy; Recovery," "Surgery of the Thymus Gland," "The Thoracic Lymphatics and the Vagus Nerves." William N. Berkeley in writing upon the subject of "Parathyroid Treatment of Paralysis Agitans," states that tetany is acknowledged as being the result of damaged parathyroids, but he is also of the opinion that this is not the only disease having relation to these glands and he suggests paralysis agitans as due to a disease or chronic chemical disorder of the parathyroids. In support of this hypothesis, he offers the following data: Paralysis agitans has all of the marks of a chronic chemical poisoning. The symptoms following parathyroidectomy are remarkably like those of paralysis agitans. In certain stages of illness a parathyroidectomized rabbit has propulsion, tremors, rigidity and salivation as perfectly as ever these signs appear in Parkinson's disease. In myxedema and exopthalmic goiter, paralysis agitans has not infrequently occurred as a complication, and it is not too wild a suggestion that the diseased thyroid has damaged the adjacent glands by contiguity of tissue. It is now possible to collate 19 recent autopsies, carefully made upon cases of Parkinson's disease, in which the parathyroids were objects of special research. In some there was unmistaken evidence of disease, in others no definite lesions could be determined. However, the weight of evidence leaned to the side of diseased glands. Taking all these facts into consideration, the writer has tested his theory clinically upon a number of cases, employing the following routine: Two capsules, each containing one-fiftieth of a grain of parathyroid nucleoproteid, are given daily. He definitely states that in paralysis agitans there are no special contra-indications, though some patients complain of nervousness, inability to sit still and aggrava-

tion of their habitual constipation after a few days' dosage. Nothing is necessary in these cases, except to diminish the dose and increase again more slowly. Little benefit can be expected of a satisfactory character, except from small doses continued over a long period of time, three months to a year. Patients taking parathyroid require no change in their mode of life, diet, or habits not otherwise indicated. Those able to attend to business should be encouraged to work, but with shorter hours and more frequent periods of repose.

After a course of treatment as above outlined in more than 100 cases during the past six years, the improvement in the symptoms certainly would lead one to believe that disease of the parathyroids is at the bottom of paralysis agitans. The clinical benefit has consisted in diminished rigidity, lessened pain, salivation cured, shaking diminished or cured, voluntary control of muscles greatly increased, and restlessness and insomnia nearly or quite abolished. The results obtained by Berkeley are indeed remarkable; therefore, his line of treatment should be given a thorough trial, as anything which offers a ray of hope to this sorely afflicted group of patients is indeed a blessing.

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A Manual of Personal Hygiene; Proper Living Upon A Physiologic Basis. By American Authors. Edited by Walter L. Pyle, A.M., M.D., Member of the American Opththalmological Society, Fellow of the American Academy of Medicine, Fellow of the College of Physicians of Philadelphia, Ophthalmic Surgeon to Mount Sinai Hospital, Assistant Surgeon to the Wills Eye Hospital, Philadelphia, etc. Contributors: D. H. Bergey, M.D.; J. W. Courtney, M.D.; George Howard Fox, M.D.; Joel E. Goldthwait, M.D.; E. Flethcher Ingals, M.D.; Walter L. Pyle, M.D.; B. Alexander Randall, M.D.; G. N. Stewart, M.D., (Edin); Charles G. Stockton, M.D.; Harvey W. Wiley, M.D. Fifth edition. Enlarged and revised. 12mo of 516 pages. Illustrated Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. 1912. Cloth, $1.50 net.

The ordinary individual is all too ignorant concerning his body and bodily functions, so that works of the above character should exert a real influence in creating a desire among the public to become better acquainted with themselves and how to keep the body in health. Personal hygiene exerts a powerful influence, either for or against health; therefore, it is better that such men as the collaborators of this book should engage in a discussion of this kind, rather than leave the public to the tender mercies of the charlatan, who preys upon their frailities. The volume is a very complete exposition on the care of the digestive organs, skin, vocal and respiratory apparatus, ear, eye, brain and nervous system, physical exercise, body posture, domestic hygiene, food

adulteration and deterioration. Written in popular style, each section gives the essential anatomy and physiology of the organ with which it deals, the methods to be employed in detecting disease and complete and exact directions as to the way to correct correctable affections. The beauty of the volume is that it is written by experts in their particular field, and can therefore be relied upon as authoritative.

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The Psychology of Insanity. By Bernard Hart, M.D. (London), Lecturer in Psychiatry, University College Hospital Medical School; Medical Superintendent Northumberland House Asylum. Cambridge University Press. The Cambridge Manuals of Science and Literature. 1912. Cloth, 40 cents net. New York: G. P. Putnam's Sons.

From the revolting misery of the asylums in the days agone to the humanitarian treatment of the unbalanced today is a far cry, and has only been accomplished by the gradual realization that insanity is a disease, not a stigma. This conception has only come about by the scientific research of a host of workers, who have labored diligently and perseveringly in the dead house, pathological, histological, physiological and other laboratories to unweave the mysteries of insanity. Thus has grown up our belief that insanity must be attacked along the lines which had led everywhere else to a better understanding of things medical. In the enthusiasm of the moment, it was believed that the nature and causes of insanity would soon be laid bare, only to be dampened by repeated failures. Consequently, another tact had to be taken if the profession was to make further advances in their conception of this most intricate of diseases. This has led to the psychological method of investigating abnormal mental processes, and is based upon the conception that mental processes can be directly studied without any reference to the accompanying changes which are presumed to take place in the brain, and that insanity may therefore be safely attacked from the standpoint of psychology. Early attempts to develop this aspect of insanity were largely vitiated by the confusion of psychology with metaphysics, theology, ethics. Finally, however, psychology succeeded in freeing itself from its alien companions, and the way was clear for its application to the study of insanity. At the present time, therefore, there are two dominating conceptions of insanity, the physiological and the psychological, differing widely in their mode of dealing with the subject, but both alike founded upon the employment of scientific methods.

It is with the psychological that this monograph deals, and one cannot help but be impressed with the advances psychologic investigations have made possible in our knowledge of insanity. It has indeed proven a helpful hand maiden to the physiologic method and has borne much fruit.

# REPORT OF BOARD OF MEDICAL EXAMINERS OF MARYLAND.

## QUESTIONS AT THE DECEMBER (1912) EXAMINATIONS.

### CHEMISTRY.

1. Define: Reagents, oxidation, precipitate, combustion and valence, and give an example of each.

2. (a) What is a base? (b) What is an acid? (c) What is a salt? (d) What is an alkaloid? (e) What is an alcohol?

3. Give one chemical test for the following when occurring in urine: (a) Sugar, (b) bile, (c) albumen, (d) blood, (e) diacetic acid.

4. Give the chemical formula of each of the following: (a) Hydrogen peroxide, (b) hydrocyanic acid, (c) calomel, (d) arsenious oxide, (e) benzene.

5. State the names and the general chemical and physical properties of the "halogens."

6. Complete the following equations:

$$Mg + H_2SO_4 =$$
$$CO_2 + Ca(OH)_2 =$$
$$CuO + 2HNO_3 =$$
$$NH_3 + HCl =$$
$$BaO_2 + H_2SO_4 =$$

7. (a) What are amalgams? (b) What are indicators? (c) What are alexins? (d) What are ptomaines? (e) What is an atom?

8. Give the chemical formula, properties and uses of magnesium sulphate.

9. Under what circumstances are the syllables mono, di, tri, tetra and penta used in chemical nomenclature? Give examples.

10. Give a chemical antidote for (a) mercuric chloride. (b) Give two tests for organic matter in water. (c) What is ozone? (d) What is the average composition of cow's milk?

### ANATOMY.

1. Describe upper extremity of the femur, including attachments of muscles.

2. Name (a) ligaments of elbow joint, and (b) bones entering into formation of radiocarpal joint.

3. Make drawing of outer surface of cerebral hemisphere showing position of lobes and chief fissuues and convolutions.

4. After ligation of common carotid artery, how is collateral circulation established?

5. What anatomical structures pass through the sphenoidal fissure (foramen lacerum anterius)?

6. Origin, course and distribution of facial nerve?

7. What structures are found between the layers of the broad ligament (ligamentum latum uteri)?

8. Describe the male urethra.

9. What glands are in the stomach?

10. Attachments, action and nerve supply of the following muscles: Rectus femoris, pronator quadratus, psoas-magnus, triceps (extensor cubiti)?

### THERAPEUTICS.

1. Write a prescription in Latin, without abbreviation, containing three ingredients or more which you would use in acute pharyngitis, and give directions for administration.

2. Write a prescription in Latin, without abbreviation, which you would use in acute rheumatic arthritis, and give directions for administration.

3. What is a prescription? Name its constituent parts.

4. Define therapeutic, chemical and pharmaceutic incompatibility, and give an example of each.

5. Give the physiological action and therapeutics of amyl nitrite.

6. Chloral hydrate, its physiological action and therapy.

7. Ergotum, physiological action and therapy in parturition.

8. Give the therapeutics of aconitum.

9. Write a prescription for an emulsion and give indications for its use.

10. Give the dose of sparteine per orem and state its therapy.

### MATERIA MEDICA.

1. (a) Define tincture, fluid extract, decoction and infusion. (b) What is the ordinary relative strength of a tincture to a fluid extract?

2. Opium—How obtained, official preparations and doses?

3. (a) What is meant by incompatibles? Name some. (b) What are the kinds of incompatibility?

4. Mercury—Name five official preparations and some of the incompatibles.

5. Name and describe six methods of introducing medicine into the system.

6. (a) What is the difference between an expectorant and an emetic? (b) Name three of each and the doses for a child three years old.

7. Name three circulatory stimulants, circulatory depressants, antispasmodics, emetics, carminatives and diuretics, and give doses of each.

8. What is the average adult dose of the following: Tincture nux vomica, tincture veratrum, tincture aconite, sulph. morph., tincture

opium, Fowler's sol. arsenic, nitroglycerine and codeine?

9. Chloral hydrate, preparation and dose?

10. Potassium — Give six official preparations, doses and incompatibles.

PHYSIOLOGY.

1. State into what general classes foods are divided. Give example of each.

2. What is the function of each class of food in nutrition?

3. (a) Name the secretions of the body and the functions of each. (b) Name the excretions of the body.

4. (a) What are the sources of animal heat? (b) Mention some of the conditions affecting heat production.

5. Describe the functions of the spinal nerves.

6. (a) What are the channels of absorption? (b) Mention the facts and conditions that favor absorption and those that retard it.

7. Give the composition, reaction, uses and specific gravity of the blood, and the causes of the variation in specific gravity.

8. (a) What do you understand by blood pressure? (b) State the cause of blood pressure in the arteries, capillaries and veins.

9. Describe the function of the mucous membrane of the respiratory tract, and the changes produced in the air and blood by respiration.

10. (a) What is the physiologic function of the liver? (b) State the origin, nature and destination of glycogen.

PATHOLOGY.

1. Describe the changes occurring in cirrhosis of the liver.

2. Describe the mode of formation of tube-casts and mention their significance.

3. Oxyuris vermicularis—Describe it and give its habits.

4. Mention the pathological changes and associated conditions present in rachitis?

5. What changes are induced by chronic phosphorus poisoning?

6. Outline briefly the method which you would pursue in order to have the pathogenicity of a certain organism found in the blood of an animal in pure culture at autopsy.

7. Mention two or more pathological conditions which would permit the spontaneous fracture of a long bone, and describe one of them.

8. Describe the changes occurring in an inflamed area which cause swelling and redness.

9. Mention the abdominal lesions present in the third week of an ordinary case of typhoid fever, and describe the conditions which precede a perforation.

10. What is the theory in regard to the action of the antitetanic vaccine? In what way does this differ in action from diphtheria antitoxin?

PRACTICE.

1. Define: (a) Kernig's sign, (b) Ludwig's angina, (c) Koplik's sign, (d) pyelitis, (e) endocarditis.

2. Define: (a) Cholelithiasis, (b) chorea major, (c) empyema, (d) pertussis, (e) Babinski's sign.

3. Differentiate: Rubeola and scarlatina.

4. Name the symptoms of Graves' disease.

5. How would you diagnose a case of infantile paralysis?

6. Name the most important diseases occurring in the right inguinal region.

7. Name the types of chronic nephritis. Differentiate each type.

8. Give treatment of pharyngeal diphtheria.

9. Give treatment of influenza.

10. Give treatment of infantile paralysis.

SURGERY.

1. What are the indications for enucleation of the eyeball? Describe an operation.

2. Symptomatology and treatment of acute catarrhal otitis media.

3. Differentiate between pernicious anemia and carcinoma of the stomach.

4. Give symptoms and treatment of coxalgia.

5. What technique and treatment would you employ for a punctured wound about the ankle caused by a pitchfork?

6. Give cause, symptoms, diagnosis, operative and post-operative treatment of rupture of the bladder.

7. Discuss the cardinal symptoms of brain tumor.

8. What is the significance of blood in the stools?

9. Give the symptoms and physical signs of carcinoma of the breast.

10. What are the causes and symptoms of intestinal obstruction?

OBSTETRICS.

1. What should be learned at the first examination in a case of labor?

2. Name the occipital presentations.

3. What is placenta prævia, and how treated? What is dystocia?

4. What is version, and how many kinds of version are there?

5. How is the cord tied and dressed?

6. Describe the method of resuscitation when the child is apparently still-born.

7. What changes in the fetal circulation occur at birth?

8. Describe the deviations of the uterus from the normal position.

9. Give the etiology and treatment of erosion of the cervix.

10. Describe the operation Cesarean section.

# Summary of Results of Examination Held by the Board of Medical Examiners of Maryland, December 10, 11, 12 and 13, 1912.

| No. | College of Graduation. | Anatomy | Surgery | Pathology | Obstetrics | Practice | Chemistry | Materia Medica | Therapeutics | Physiology | Total | Average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | University of Pennsylvania, '12 | 77 | 75 | 83 | 88 | 80 | 82 | 88 | 94 | 80 | 747 | 83 |
| 2 | Georgetown Medical, '11 | 70 | .. | .. | .. | .. | .. | 56 | 58 | .. | ... | .. |
| 3 | Maryland Medical, '12 | 64 | 69 | 91 | .. | .. | 65 | 75 | .. | .. | ... | .. |
| 4 | Maryland Medical, '12 | .. | .. | 80 | .. | 78 | 88 | 75 | 75 | 75 | ... | .. |
| 5 | Maryland Medical, '12 | 61 | .. | .. | .. | .. | 76 | 75 | 91 | 75 | ... | .. |
| 6 | Baltimore Medical, '12 | 75 | 71 | 95 | 80 | 89 | 83 | 84 | 62 | 87 | 726 | 81 |
| 7 | Jefferson Medical, '12 | 81 | 76 | 89 | 89 | 83 | 96 | 61 | 78 | 84 | 737 | 82 |
| 8 | Medical and Chirurgical, Phila., '10 | 82 | 78 | 83 | 78 | 75 | 82 | 84 | 77 | 75 | 714 | 79 |
| 9 | Medical and Chirurgical, Phila., '12 | 67 | 66 | 68 | 95 | 71 | 77 | 67 | 75 | 45 | 631 | 70 |
| 10 | Medical and Chirurgical, Phila., '12 | 68 | 66 | 91 | 90 | 85 | 79 | 80 | 84 | 75 | 718 | 80 |
| 11 | Maryland Medical, '12 | 66 | 75 | 89 | 83 | 78 | 75 | 60 | 64 | 63 | 653 | 72 |
| 12 | Maryland Medical, '12 | 55 | 75 | 71 | 65 | 75 | 60 | 52 | 61 | 50 | 564 | 62 |
| 13 | Baltimore Medical, '12 | 78 | 61 | 97 | 88 | 71 | 91 | 82 | 85 | 78 | 731 | 81 |
| 14 | University of Maryland, '12 | 78 | .. | .. | .. | .. | .. | 81 | 75 | 80 | ... | .. |
| 15 | Maryland Medical, '12 | .. | .. | 87 | .. | .. | 68 | 50 | 71 | 50 | ... | .. |
| 16 | Maryland Medical, '12 | Failed to appear. | | | | | | | | | | |
| 17 | Medical and Chirurgical, Phila., '11 | 86 | 76 | 90 | 83 | 80 | 79 | 82 | 92 | 75 | 748 | 83 |
| 18 | University of Maryland, '11 | 60 | 76 | 73 | 75 | 63 | 86 | 75 | 72 | 75 | 655 | 73 |
| 19 | University of Maryland | 87 | .. | .. | .. | .. | 84 | 83 | .. | 80 | ... | .. |
| 20 | Maryland Medical, '12 | 63 | 42 | 38 | 75 | 51 | 75 | 50 | 56 | 40 | 490 | 54 |
| 21 | Maryland Medical, '12 | 75 | .. | .. | .. | 75 | 75 | .. | 75 | 76 | ... | .. |
| 22 | Jefferson Medical, '02 | 60 | 69 | 70 | 75 | 75 | 53 | 58 | 81 | 31 | 572 | 63 |
| 23 | Baltimore Medical, '12 | 66 | .. | 71 | .. | 71 | .. | .. | .. | .. | ... | .. |
| 24 | College of Physicians and Surg., Balto., '12 | 76 | 77 | 81 | 95 | 84 | 78 | 79 | 78 | 75 | 723 | 80 |
| 25 | George Washington University, '11 | 82 | .. | 48 | 78 | 75 | 70 | 65 | 70 | 75 | 563 | 62 |
| 26 | Maryland Medical, '10 | 56 | 61 | 60 | 55 | 70 | .. | 62 | .. | 48 | ... | .. |
| 27 | University of Maryland, '11 | 84 | 76 | 95 | 95 | 84 | 98 | 95 | 81 | 52 | 760 | 84 |
| 28 | University of Pennsylvania, '12 | 78 | 84 | 99 | 93 | 78 | 75 | 83 | 92 | 77 | 759 | 84 |
| 29 | Woman's Medical College of Pa., '10 | 72 | 56 | 71 | .. | 56 | 75 | 75 | .. | 75 | ... | .. |
| 30 | University of Maryland, '12 | 70 | 67 | 91 | 92 | 75 | 83 | 75 | 85 | 75 | 713 | 79 |
| 31 | Johns Hopkins, '11 | 60 | 73 | 94 | 91 | 75 | 85 | 80 | 75 | 91 | 724 | 80 |
| 32 | University of Pennsylvania, '12 | 61 | 76 | 83 | 83 | 88 | 76 | 82 | 84 | 69 | 702 | 78 |
| 33 | Maryland Medical, '12 | Failed to appear. | | | | | | | | | | |
| 34 | Maryland Medical, '12 | 58 | 75 | 89 | 87 | 75 | 75 | 80 | 93 | 62 | 694 | 77 |
| 35 | Baltimore Medical | 59 | .. | .. | .. | .. | 75 | 75 | .. | 36 | ... | .. |
| 36 | College of Physicians and Surg., '12 | 94 | 79 | 91 | 87 | 84 | 76 | 88 | 81 | 90 | 770 | 85 |
| 37 | Maryland Medical, '12 | 93 | 75 | .. | .. | 77 | 84 | .. | 82 | .. | ... | .. |
| 38 | Medical and Chirurgical, Phila., '12 | 57 | 63 | 76 | 75 | 75 | 75 | 66 | 69 | 59 | 615 | 68 |
| 39 | Maryland Medical, '12 | Failed to appear. | | | | | | | | | | |
| 40 | Maryland Medical, '12 | 59 | 71 | 89 | 81 | 75 | 92 | 57 | 75 | 57 | 656 | 73 |
| 41 | University Col. of Medicine, Richmond, '12 | 45 | 76 | 79 | 97 | 75 | 79 | 66 | 83 | 75 | 675 | 75 |
| 42 | College of Physicians and Surg., Balto., '12 | 90 | 79 | 88 | 75 | 81 | 82 | 78 | 90 | 80 | 743 | 82 |
| 43 | Temple University, '12 | 65 | 75 | 82 | 82 | 83 | 77 | 63 | 80 | 75 | 682 | 76 |
| 44 | College of Physicians and Surg., Balto., '12 | 82 | 82 | 97 | 81 | 82 | 75 | 75 | 91 | 53 | 718 | 80 |
| 45 | Maryland Medical, '12 | 38 | 39 | 32 | .. | 39 | 75 | 25 | 34 | 21 | ... | .. |
| 46 | Jefferson Medical, '12 | 57 | 75 | 76 | 80 | 82 | 69 | 80 | 86 | 70 | 675 | 75 |
| 47 | Maryland Medical, '10 | 70 | 80 | 75 | 75 | 72 | 89 | 80 | 64 | 75 | 675 | 75 |
| 48 | George Washington University, '12 | 86 | 86 | 96 | 79 | 78 | 87 | 76 | 84 | 77 | 749 | 83 |
| 49 | Howard University, '11 | 81 | 71 | 87 | 90 | 78 | 91 | 88 | 77 | 83 | 746 | 83 |
| 50 | Howard University, '12 | 59 | 74 | 73 | 72 | 81 | 76 | 64 | 60 | 54 | 604 | 67 |
| 51 | University of Maryland, '12 | 57 | 76 | 78 | 94 | 76 | 75 | 77 | 70 | 76 | 679 | 75 |
| 52 | Meharry Medical, '12 | 54 | 44 | 76 | 63 | 60 | 59 | 50 | 54 | 36 | 496 | 55 |
| 53 | College of Physicians and Surg., Balto., '12 | 62 | 70 | 75 | 77 | 83 | 81 | 67 | 86 | 75 | 676 | 75 |
| 54 | Maryland Medical, '12 | Failed to appear. | | | | | | | | | | |
| 55 | College of Physicians and Surg., Balto., '12 | 70 | 75 | 86 | 70 | 77 | 75 | 75 | 76 | 77 | 681 | 76 |
| 56 | University of Maryland | 35 | .. | .. | .. | .. | 53 | 40 | .. | 39 | ... | .. |
| 57 | College of Physicians and Surg., Balto., '12 | 94 | 76 | 90 | 92 | 82 | 86 | 78 | 79 | 78 | 755 | 84 |
| 58 | College of Physicians and Surg., Balto., '12 | 85 | 75 | 80 | 80 | 75 | 79 | 78 | 76 | 75 | 703 | 78 |
| 59 | University of Maryland | 47 | .. | .. | .. | .. | 69 | 77 | .. | 75 | ... | ... |
| 60 | University of Maryland, '11 | 88 | 75 | 86 | 94 | 81 | 82 | 77 | 85 | 79 | 747 | 83 |
| 61 | University of Pennsylvania, '12 | 92 | 88 | 96 | 93 | 88 | 85 | 84 | 88 | 80 | 794 | 88 |
| 62 | University of Maryland, '12 | 80 | 83 | 87 | 92 | 88 | 76 | 80 | 75 | 65 | 726 | 81 |
| 63 | University and Bellevue Hosp., N. Y., '05 | 89 | 79 | 96 | 92 | 81 | 85 | 84 | 84 | 75 | 765 | 85 |
| 64 | Baltimore Medical, '11 | 83 | .. | 80 | .. | .. | .. | .. | 75 | 75 | ... | .. |
| 65 | University of Maryland, '12 | 81 | 75 | 86 | 81 | 84 | 71 | 75 | 66 | 78 | 697 | 77 |
| 66 | Maryland Medical, '12 | Failed to appear. | | | | | | | | | | |
| 67 | University of Maryland, '12 | 96 | .. | .. | 94 | .. | .. | .. | 85 | .. | ... | .. |
| 68 | College of Physicians and Surg., Balto., '12 | 65 | 73 | 69 | 88 | 60 | 62 | 65 | 61 | 60 | 603 | 67 |
| 69 | Maryland Medical, '12 | 89 | .. | 78 | .. | 75 | 88 | 78 | 76 | .. | ... | .. |
| 70 | University of Maryland, '12 | 82 | 84 | 87 | 91 | 88 | 96 | 75 | 77 | 75 | 755 | 84 |
| 71 | Maryland Medical, '11 | 62 | 70 | 79 | 78 | 56 | 77 | 75 | 59 | 59 | 615 | 68 |
| 72 | Maryland Medical, '06 | 78 | .. | 78 | .. | .. | .. | .. | .. | .. | ... | .. |
| 73 | Starling, Ohio Medical University, '03 | 52 | 56 | 43 | 91 | 49 | 93 | 57 | 57 | 51 | 543 | 60 |

In the above summary an average of 75 is required of those participating in the examination for the first time in order to secure a license. Those who have failed are eligible to re-examination at the expiration of six months. They are then obliged to receive a rating of 75 in each branch in which they are re-examined before license can be issued. Under the Maryland laws, students who, at the end of their second year, have successfully passed their college examination in Anatomy, Chemistry, Meteria Medica and Physiology, are entitled to examination by the Board of Medical Examiners in these branches. The ratings made by these students in the examination known as the "second-year examination" are carried forward and made part of the final examination, when an average of 75 must be obtained to secure a license. We trust that this statement will make clear the apparently incomplete examination of certain participants.

# MARYLAND MEDICAL JOURNAL

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BALTIMORE, FEBRUARY, 1913


## THE LATE DR. JAMES BOSLEY.

IT is with much regret that the JOURNAL announces the death of Dr. James Bosley, late Health Commissioner for Baltimore city, which occurred January 5, 1913, at his home, 412 Cathedral street, from pneumonia, aged 60 years. Since entering upon the duties of Health Commissioner in 1900, Dr. Bosley, through his interest in progressive health legislation, became widely and favorably known throughout the country as a sanitarian of signal ability. Dr. Bosley entered the municipal service as vaccine physician, serving two years, 1878-1880, and was School Commissioner from 1889-1897. He was appointed Health Commissioner for Baltimore in 1900 by ex-Mayor Thomas G. Hayes and was reappointed by Mayor McLane, Mayor Mahool and Mayor Preston. While holding this office, he worked incessantly for the betterment of Baltimore's health conditions, for which work he gained national repute as a sanitarian. He was instrumental and active in the obtaining of needed legislation for the safeguarding of the city's health, but the chief achievement of his administration was the establishment of the Sydenham Hospital for Infectious Diseases. Baltimoreans take especial pride in Dr. Bosley's career in that he was a native Baltimorean and educated in the private and public schools of the city and county. He received his degree of Doctor of Medicine in 1874 from the University of Virginia. After graduation he returned to Baltimore, where he entered upon the practice of medicine and soon built up a large and lucrative practice in the west end. In 1900, much against his will and inclinations, he was persuaded by ex-Mayor Thomas G. Hayes to assume the responsibilities of Health Commisssioner. He was a member of the American Medical Association and the Medical and Chirurgical Faculty of Maryland. He is survived

by his wife, who was Miss Ruth Waters, a son and daughter. He died as the result of his devotion to duty and his love in serving humanity. He was an indefatigable worker, laboring in season and out of season, to make his administration of the Health Department a success, the pathway to which he thoroughly believed was in serving humanity.

"But whether on the scaffold high,
Or in the battle's van,
The fittest place where man can die
Is where he dies for man."

---

## NEW MEN IN OLD PLACES.

THE death of Dr. Bosley and the filling of his place as Health Commissioner of Baltimore by Dr. Nathan Ryno Gorter; the resignation of Dr. Marshall Langdon Price because of ill-health, and the naming of Dr. John Samuel Fulton as the new secretary of the Board of Health in his stead, are changes which the past month has brought.

Dr. Gorter takes up his work at a time when the city is suffering from a smallpox scare, and the work of his office is unusually heavy and responsible. He has taken hold of the situation in a way that presages well for the new administration, and our cordial good wishes are extended to him.

Dr. Fulton simply comes home again, as he is distinctly a Marylander. He was educated in this State, graduated from her oldest medical institution, served her many years as a private practitioner in the counties, and then in Baltimore, and was from 1896 to 1907 secretary of the State Board of Health, and therefore well acquainted with the work to which he is returning. He was for several years editor of the MARYLAND MEDICAL JOURNAL, and afterwards became secretary-general of the International Congress of Tuberculosis; and with the unusual combination of a personal knowledge of county and city practice and State and national and international public health work, comes to the work he resigned in 1907 better equipped for it, possibly, than any other health board secretary in the country. Of Dr. Marshall Langdon Price, Dr. Fulton's own words best describe him and his work: "The State of Maryland will lose an unusually efficient man," and we wish for him a speedy restoration to health and work in this community.

## Medical Items.

President Taft has appointed Dr. William C. Lyon of Baltimore an assistant surgeon in the Medical Reserve Corps of the Navy.

Dr. John W. Ebert has settled for practice in Winchester, Va.

Drs. Rupert Blue, Surgeon-General of the Public Health Service of the United States; Henry R. Carter, J. A. Nydegger and C. H. Stiles will deliver a series of lectures on tropical diseases at the University of Maryland.

Dr. Li Bi Cu, of Nyucheng, China, is taking a post-graduate course in medicine at the Johns Hopkins Hospital.

Dr. William Lee Howard's private sanitarium at Westboro, Mass., for the study and treatment of morbid psychological cases, is now in charge of Dr. Von Belibestein, a former assistant of Dr. Kraft-Ebing. Dr. Howard, formerly of Baltimore, is editorially connected with the Magazine syndicate of this country.

A committee has been appointed to manage the affairs of the Johns Hopkins University until a president is elected. Dr. William H. Welch has been appointed chairman of this committee.

Dr. Charles Wellman Mitchell has been quite ill of grip, but is now well on the way to recovery.

Dr. Alan M. Chesney of the Johns Hopkins Hospital will spend six months as assistant resident physician in Rockefeller Institute, New York, returning to the Hopkins in August.

Dr. Thomas Fell has been elected provost of the University of Maryland, succeeding the late Bernard Carter.

Dr. Henry R. Carter has been appointed superintendent of the Marine Hospital, succeeding Dr. W. P. McIntosh.

The engagement is announced of Miss Lucy Perry, daughter of Mrs. S. M. Perry, of Atlanta, Ga., to Dr. Emmett O'Brien Taylor, University of Maryland, '11, of Greeleyville, N. C.

Dr. Frederick Henry Vinup has been appointed assistant surgeon of the Fourth Regiment, Maryland National Guard, succeeding Dr. J. Harry Ullrich, now chief surgeon of the regiment.

New internes have been appointed at the Hopkins Hospital as follows:

Medical—R. L. Levy, W. G. Carlisle and F. J. Smith.

Gynecological—W. W. Young, W. R. Holmes and E. C. Fishbaugh.

Surgical—M. H. Todd, L. T. Post, Edward Jelks and H. L. Cecil.

Pediatrics—L. D. Minsk, J. R. Turner and G. F. Powers.

Obstetrical—N. M. Canter.

Miss Roberta L. Ball, formerly superintendent of nurses in the Union Protestant Infirmary, has been appointed superintendent of the Infirmary, succeeding Dr. William M. Dabney.

Dr. Oswald S. Lowsley, who served for five years as instructor of athletics at the Baltimore Athletic Club, has been appointed an interne in surgery in Bellevue Hospital, New York.

Mr. and Mrs. Abraham Rogers, of Boston, Mass., announce the engagement of their daughter, Elizabeth Grace, to Dr. Emil Novak, Baltimore Medical College, '04, of Baltimore. The marriage will be solemnized on March 24, 1913.

The Central Directory of Registered Nurses, Inc., has appointed the following officers for the coming year:

President—Sarah F. Martin.

Vice-President—Sarah Haydock.

Secretary Register—C. E. Query.

Treasurer—Mary C. Packard.

Board of Members—Mary E. Lent and Anna Short.

Governor Goldsborough entertained Drs. Lewellys S. Barker, William S. Thayer and C. Hampson Jones of Baltimore at dinner January 10. These gentlemen later addressed a meeting of the House of Delegates at the State House in the interest of the permanent organization of a local branch of the Society for the Prevention and Relief of Tuberculosis.

Dr. Benjamin B. Turner has been appointed assistant in pharmacology and Dr. Caroline B. Towles assistant in pediatrics in Johns Hopkins Medical School.

The committee of public instruction of the Medical and Chirurgical Faculty of Maryland has planned a mental hygiene week late in February. Elaborate exhibits on mental hygiene

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## SHARP & DOHME

***The Hypodermic Tablet People***

**BALTIMORE, MD.**

and temperance will be shown, and papers will be read on topics relating to mental health, eugenics, alcoholism, etc. This congress will be followed by smaller meetings in various parts of the city and surroundings.

Dr. E. M. Duncan has been elected president of the Govans Improvement and Protective Association.

Dr. Horace W. Nicholson is ill in Mercy Hospital.

Dr. George C. Wegefarth, who was operated on for appendicitis at the Church Home and Infirmary December 12, is making satisfactory progress.

Dr. John C. Harris, who suffered a cerebral hemorrhage several months ago, fell from his window to the cellarway recently, suffering severe cuts and bruises.

Dr. John M. T. Finney has been appointed professor of clinical surgery in Johns Hopkins University.

At the annual meeting of the Hebrew Hospital, held January 12, gifts were announced of a mattress sterilizer, valued at $1500, and of $4000 through Dr. Charles Bagley, Jr., as a foundation for the pathologic fund. A new nurses' home has been added during the year.

Dr. Walter G. Sexton has been made resident surgeon of the Hebrew Hospital.

A tuberculosis clinic is to be opened in the basement of the new city hall, Cumberland. A visiting nurse will be in charge, and five physicians have volunteered to assist.

Dr. Thomas R. Boggs has been made physician-in-chief of the City Hospital.

Dr. Charles A. Wells has been elected president of the Upper Marlboro Bank.

The psychiatric clinic of Johns Hopkins Hospital will open April 16, with accommodation for 100 patients.

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### MARRIAGES.

James Erwin Diehl, M. D., University of Maryland, '77, of Trenton, N. J., to Miss Lillie May Tucker, of Raleigh, N. C., at Raleigh, January 18, 1913.

Robert Preston Winterode, M. D., Baltimore Medical College, 1900, of Crownsville, Md., to Miss Emma Victoria Horn of Mount Airy, Md., at Baltimore, January 22, 1913.

Howard LeRoy Dovey, M. D., Maryland Medical College, '11, of Dudley, Pa., to Miss Mary Bronner, of Baltimore, at Philadelphia, June 1, 1912.

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### DEATHS.

James Bosley, M. D., University of Virginia, '74, Health Commissioner of Baltimore since 1900, died at his home on January 5, 1913, from pneumonia, aged 60 years.

Richard Channing Massenburg, M. D. University of Maryland, '67, died at his home in Towson, Md., December 30, 1912, from diabetes, aged 67 years.

Charles L. Kennedy, M. D., College of Physicians and Surgeons, '97, was struck by a train and instantly killed at Troy, N. C., December 26, 1913, aged 38 years.

Oliver Parker Penning, M. D., University of Maryland, '97, died at his home in Baltimore December 29, 1912, of splenomyelogenous leukemia, aged 43 years.

Raymond H. Pillow, M. D., Jefferson Medical College, '76, of Butler, Pa., died at his home January 10, 1913, of cerebral hemorrhage, aged 59 years.

Thomas Clinton Baldwin, M. D., University of Maryland, '94, died at his home in White Hall, Md., January 3, 1913, of nephritis, aged 44 years.

John A. Burlington, M. D., Baltimore Medical College, '90, died at his home in Duryea, Pa., December 31, 1912, from pneumonia, aged 55 years.

Edward Lawrence Casey, M. D., University of Maryland, '05, died at his home in North Woodstock, N. H., December 10, 1912, aged 30 years.

William Henry Smith, M. D., Baltimore Medical College, 1900, died at his home in Unionville, N. C., December 5, 1912, from the effects of an overdose of phenol, aged 41 years.

Benjamin T. Winchester, M. D., University of Maryland, '75, died at his home in Windsor Hills, Md., January 14, 1913, aged 62 years.

Millard May Von Wachter, M. D., Northwestern Medical College, '85, of Long Island, Kansas, died at the home of his brother, in Baltimore, of Bright's disease, aged 58 years.

Robert John Price, M. D. University of Maryland, '66, died at his home in Vienna, Md., of paralysis, January 15, 1913, aged 73 years.

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## SOME ENDOSCOPIC METHODS.

*By Richard H. Johnston, M.D.,*
Baltimore.

During the past few years so many papers have appeared on direct laryngoscopy, bronchoscopy and esophagoscopy it seems superfluous to add another to the list. The constant introduction of new instruments, however, proves that laryngologists are still seeking simpler methods which will enable them to work successfully in these fields. To try to help in the simplification of the work and to add my experiences to the rapidly-growing literature are my excuses for submitting this paper to the American Laryngological, Rhinological and Otological Society.

By way of preface I wish to say that to learn direct laryngoscopy, bronchoscopy and esophagoscopy well is one of the most difficult problems in surgery; that, once mastered, they are easy, and can be successfully used in practically every patient free from deformity. In order to become skilful much practice is required, which necessitates a connection with a large general or special hospital where material can be obtained in abundance. Many hours must be spent in learning proper methods of anesthetizing and in manipulating the various instruments. After long practice a certain knack of handling the instruments so as not to cause pain is acquired. It seems to me that the real reason for the want of popularity of these methods is the multiplicity of instruments. When one enters a modern instrument store and sees the large number of instruments apparently required for the work he is appalled. As a matter of fact, most successful work can be done with few instruments. It may be said, as a general rule, that one who has mastered direct laryngoscopy will have little trouble in passing the bronchoscope or the esophagoscope. When the laryngologist has become expert in the use of the tubes he will practically discard the indirect method for operative procedures. The fact that he sees the lesion directly, that with practice he acquires an accu-

rate perspective, gives him an immense advantage over the mirror. Since perfecting my own methods I have not used the mirror for any operative procedure in the larynx. I feel that I can do better and quicker work, and that lesions difficult or impossible of removal by the mirror can be successfully handled through the tube.

*Direct Laryngoscopy.*—Before describing the methods which have greatly simplified direct laryngoscopy for me I wish to refer briefly to two positions of the head which have had their origin in America. The "Boyce position" was worked out by Dr. J. W. Boyce of Pittsburgh, and is fully described in Jackson's work on tracheo-bronchoscopy. The head is lowered over the end of the table and held in the proper position by an assistant. Jackson emphasizes the fact that the head must be held just right, which necessitates a trained assistant. Such a man can be obtained where one works constantly in the same hospital, but if he should be so situated that he could not get his assistant, he would be at a disadvantage. When the Boyce position is used the operator sits on a low stool in a more or less cramped position, and is dependent on the man who holds the head. The laryngeal speculum is introduced with the left hand, and when the epiglottis comes into view it and the base of the tongue are pulled up and a view of the larynx obtained. The strain on the forearm in holding the speculum is so great that the instrument cannot be long held in position, and one must operate quickly, which endangers the integrity of normal tissues. In April, 1908, Mosher described the "left lateral route," which consisted in turning the patient's head to the left until the left cheek almost touched the plane of the table, and then flexing the head on the chest. A special spatula was passed down between the left bicuspid teeth, the tongue pushed to the side and the epiglottis raised, which gave a good view of the larynx. I believe this method was used first in examining the upper end of the esophagus and was later applied to the larynx. Mosher's first instruments were too large and cumbersome for use in every case. He has since had them made smaller. In the summer of 1908 I had under treatment multiple papillomata of the larynx in a child four years of age. I had made the diagnosis with the head in the "Boyce position," but had not been able to do much in an operative way. I tried Mosher's method unsuccessfully. I then conceived the idea of passing the old Jackson speculum between the incisor teeth, with the head straight on the table. A good view of the larynx was obtained. Since then I have used no other method in the examination and treatment of the larynx in children and in adults under general anesthesia. Before describing the straight method as opposed to extension and flexion it will perhaps be better to mention direct laryngoscopy in the sitting position. From an extended experience with the position that I will describe I believe it is possible to examine practically all adults under local anesthesia. If the patient has a sensitive throat or seems at all nervous, I make it a rule to give two or three days

before the examination large doses of bromides, which do good in controlling the cough reflex and in allaying nervousness. On the day of the examination the patient is instructed to eat a good lunch, since a full stomach seems to have some effect in preventing poisonous symptoms from the anesthetic, and to report at the hospital at a certain hour. A half-hour before the examination the nurse gives the patient a hypodermic injection of morphine (¼ to ⅛ gr.) and atropine (1/150 gr.). The patient is seated on a low stool, with the head slightly extended and supported—not held—by a nurse. Formerly I used cocaine for anesthetizing, but two cases of slight poisoning led me to substitute alypin (20 to 25 per cent. solution), which seems to work as well. The pharynx, base of tongue and epiglottis are deadened with a curved applicator. In about five minutes the direct laryngoscope is introduced and the anesthetization completed through it. I wish to emphasize the fact that when the laryngoscope is ready for introduction the head should be slightly extended and turned to the right or the left, according as the operator may desire to enter the mouth from the left or the right side. With the mouth open the instrument is introduced between the bicuspid teeth, and as it passes down the tongue is pushed to the opposite side. When the epiglottis comes into view the spatula end of the laryngoscope is passed behind it, and slight pressure upward on the handle suffices to bring the larynx into view. If the anterior commissure is not seen, the nurse is told to push the head forward until the straight position is assumed, when all parts of the larynx can usually be seen clearly. It is remarkable how little force is exerted on the instrument in this method. In some cases the weight of the speculum almost brings the larynx into view. The right hand is free for any operative procedure. One advantage of the method is that with the instrument in a straight position the head can be brought from left or right to an erect posture. This movement throws the instrument to the right or left so that small tumors of the cords can be approached from the side, which makes removal easier. Other advantages are the shortening of the distance from the teeth to the larynx, the slight danger of injuring teeth, the pushing of the tongue to the opposite side, and the complete relaxation of all neck muscles. With this method and the use of the Jackson instruments I have never failed to get a good view of the larynx at the first sitting. It can be confidently asserted that in most patients operations can be successfully performed at the first attempt. This method will be found far superior to the passage of the instrument between the incisor teeth, which compels more extension of the head, the pressure of the tongue against the floor of the mouth, more force on the instrument to see the larynx, with frequent failure to see the anterior commissure. There is also greater danger of injuring or displacing teeth. In children under six years of age I always use the straight method of direct laryngoscopy without anesthesia of any kind for examining and operating. The

method of procedure is as follows: With no preliminary preparation the little patient is securely pinned in a sheet so that the arms and legs are practically immovable. He is then placed flat on the table, with the head in the normal straight position. An assistant stands at the head of the table and holds the head so that it cannot be moved, while the nurses look out for the arms and legs. The operator stands at the left of the table facing the patient, and holds the Jackson modified speculum in the left hand. The mouth is forced open, if necessary, with the thimble and the instrument is passed straight down between the incisor teeth. When the epiglottis comes into view it is hooked up with the spatula end, and by raising the handle of the speculum slightly the larynx is seen. In most cases the entire larynx is seen; if, however, the anterior commissure does not come into view, the thyroid cartilage is pushed back by an assistant. The entire procedure takes a few seconds. There is no traumatism, and the child leaves the table unhurt. I have made repeated examinations in the same patient to watch the progress of papillomata, and have yet to see any bad results. The method is simple, easy and quick, and gives the best possible view of the larynx. It may be of interest to refer to the modified Jackson laryngoscope. In my earlier work I used his old laryngeal speculum, which I believe is now obsolete. I wish to say in defense of it that it is a most valuable instrument for the examination of the upper end of the esophagus in children in the extended position. While the instrument worked well, it was so long as to be unwieldy. To obtain an instrument more suitable for a child's throat I had the vertical part of the handle of the slide speculum cut off and a screw arranged in it so that it can be attached or detached at will. With detached handle the speculum is ideal for the straight method in children with or without anesthesia. With handle attached the instrument is ready for use in the sitting position. Those who master the methods described above will find direct laryngoscopy so easy that the work will become a pleasure. There is no need for complicated instruments, which are calculated to make the beginner believe that direct laryngoscopy is a formidable procedure.

*Bronchoscopy.*—I think all bronchoscopists will admit that the most difficult stage in bronchoscopy is in passing the instrument between the vocal cords. Once below the cords it takes no special skill to push the tube further down. The usual way, and, so far as I know, the only way, of passing the bronchoscope is with the head in extension either in the sitting position under local anesthesia or over the end of the table under general anesthesia. In extension under general anesthesia the same difficulties are encountered as in direct laryngoscopy. In order to prevent the strain on the forearm and the necessity of overcoming the tenseness of the neck muscles I attempted to pass the bronchoscope with the head in the straight position. With the head flat on the table the laryngoscope is passed as above described. When the larynx is

brought into view the bronchoscope is passed through the speculum until the vocal cords are reached. The eye is transferred to the end of the smaller tube, which, under the influence of a slight twisting motion, slips between the vocal cords. The slide speculum is now removed; the bronchoscope left in situ, supported by an assistant; the head gently lowered over the end of the table, and the examination proceeded with as in extension. In passing the bronchoscope the operator stands to the left as in direct laryngoscopy. In working in the larynx under general anesthesia it is always well to use a weak cocaine solution to prevent reflexes. Some time ago it occurred to me that it might be possible to pass the bronchoscope and examine the trachea and bronchi without lowering the head over the end of the table, thus doing away with the necessity of a trained assistant and giving the operator more room and allowing him a more comfortable position while working. In this method the patient is placed on a rather high cushion, while the head and shoulders are supported by another cushion. The laryngoscope and bronchoscope are passed in the straight position as above described. With the bronchoscope in position the cushion under the head is removed and the head allowed to drop to the plane of the table. With the head touching the table an assistant, who stands at the side, is instructed to raise the head or to move it from side to side as the operator desires. The bronchoscope is passed down and the examination proceeded with. In this position one is surprised how little extension is necessary for successful work. The operator sits on a stool at the head of the table, and is much more comfortable than with the head over the end. I believe the method is destined to be of great value.

*Bronchoscopy in the Sitting Position.*—Under local anesthesia the laryngoscope is introduced as above described. With the head slightly extended and turned to the side, the entire larynx is seen clearly. The bronchoscope is passed through the laryngoscope, and without regard to the breathing or the movements of the cords is gently pushed into the trachea. The procedure takes only a few seconds.* A point of great importance in all these positions of the head is the fact that larger tubes can be passed than with the head in extension.

*Esophagoscopy.*—The examination of the upper end of the esophagus can be made in two ways. With the head over the end of the table, Jackson's old laryngoscope in children is passed behind the larynx, which is lifted up and a good view of the esophagus obtained. The second method is that of Mosher, which has been described above. His instrument is used and is passed into the esophagus, which opens up almost to the clavicle. A third

*I now seldom use the laryngoscope for passing the bronchoscope in the sitting position. After anesthetizing the larynx I pass the bronchoscope from the side with the patient's head practically straight. With the end of the instrument the epiglottis is pulled forward and the bronchoscope easily passed between the cords. This method takes less time than passing the bronchoscope through the laryngoscope. The majority of patients complain more of the laryngoscope than the bronchoscope.

method, which can be used in children quickly and easily without anesthesia, is as follows: The child is pinned in a sheet and placed on the table as in the straight method of direct laryngoscopy. The head is held and the modified laryngoscope is passed until the larynx comes into view. The spatula end of the instrument is now passed behind the larynx, and slight pressure on the handle suffices to open up the mouth of the esophagus for two inches. In this way a stricture or a foreign body can be quickly diagnosed and the foreign body removed as easily as with the head in extension. The operator stands during the examination as in direct laryngoscopy. In adults under general anesthesia the same method may be used in examining the upper end of the esophagus.

In all the methods described no complicated instruments are used. My armamentarium for examining the larynx and esophagus consists of a thimble and Jackson's two laryngoscopes, the old speculum and the modified laryngoscope. The greatest advantage of these methods is the fact that one does not need trained assistants. I have worked successfully in hospitals where the assistants had never seen such work.

To illustrate the ease with which the methods can be used I wish to cite briefly a few cases which have been treated during the past year.

A little girl, two years old, was brought to me from Winston-Salem, N. C., with the history of having swallowed a chicken bone. Four days before, while eating soup, she suddenly had a choking spell, during which she nearly died. Dr. T. W. Davis located the bone in the larynx and attempted to remove it with the mirror. He did not succeed, and brought her to the Presbyterian Hospital for examination with the direct laryngoscope. The little patient was placed on the table with the head in the straight position, the laryngoscope passed, and the bone located between the vocal cords. It required only a few seconds to grasp the foreign body and to remove it with Pfau's forceps. Recovery was prompt, with no reaction. The bone was so tightly wedged between the cords that some force had to be used to dislodge it. Why the child did not suffocate is a mystery, since there seemed no breathing space left.

Dr. J. L. Hirsch referred a boy five years old to me for aphonia of long standing. Since it was impossible to examine the patient with the mirror, he was examined at the hospital with the head in the straight position. No difficulty was experienced in getting a good view of the larynx. The diagnosis was multiple papillomata, involving chiefly the anterior part of the larynx. A few days later a large mass of papillomatous tissue was removed, with the head in the same position, without anesthesia. This patient has been examined several times, and applications of alcohol made to try to shrink up the tissue which remains in the anterior commissure. None of these examinations have taken more than a few seconds, and the little patient does not mind them.

Mrs. R. M., 30 years old, was referred to me by Dr. M. L. Todd

for huskiness of the voice following the discovery of a tubercular lesion at one apex. The patient was very nervous, and it was only after the use of a strong cocaine solution that the larynx could be seen with the mirror. The posterior wall showed a suspicious thickening. A few days later the patient was sent to the hospital and the tissue removed, with the head slightly extended and turned to the right. The laryngoscope was introduced between the left bicuspid teeth. A splendid view of the vocal cords was gotten. The operation was completed in a few minutes.

Mr. N., 26 years old, was referred to me by Dr. St. Clair Spruill for a deviated septum and a huskiness of the voice of seven years' standing. He had previously had three unsuccessful operations with the mirror for a tumor of the left vocal cord. The growth was situated on the cord near the anterior commissure. Under cocaine anesthesia the papilloma was removed at the first sitting, with the head slightly extended and turned to the left. There was little reaction following the operation.

In December, 1910, a patient was referred to me by Dr. F. M. Winchester of Charlotte, N. C. Five days previously he had aspirated a scarfpin which proved to be in the right bronchus. Under general anesthesia, with the head straight on the table, the bronchoscope was passed. The head was then lowered over the end of the table and the examination proceeded with.

A boy, eight years old, developed dyspnea, for which no cause could be found. Under general anesthesia the bronchoscope was passed, with the head in the straight position. The head was then lowered as in the Boyce position.

807 North Charles street.

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SKIN GRAFTING. For Surgeons and General Practitioners. By Leonard Freeman, B. S., M. A., M. D., Professor of Surgery in the Medical Department of the University of Colorado; Surgeon to St. Joseph's Hospital, the National Jewish Hospital, and the City Hospital, Denver, Colo. With 24 Illustrations. St. Louis: C. V. Mosby Company. 1912. Cloth, $1.50 net.

Those interested in skingrafting will find this little monograph very helpful in clearing up obscure points. It goes very thoroughly into the various methods of transferring skin from one portion of the body to the other, the advantages and disadvantages of each and the causes of failure after skingrafting. The technic can be depended upon as thoroughly reliable and any one looking for authoritative information upon this subject cannot do better than procure the above-mentioned book. The illustrations, though not numerous, are exceedingly helpful and well selected. It gives us great pleasure to put our stamp of approval upon the volume and we give it our heartiest endorsement.

# THE PRESENT STATUS OF TYPHOID VACCINATION IN MARYLAND.*

*By F. W. Hachtel, M.D., and H. W. Stoner, M.D.*

From the Bacteriological Laboratory of the State and City Boards of Health, Baltimore, Md.

It is with some hesitancy that we again essay to write upon this almost threadbare subject, and can only urge in extenuation a few interesting points we desire to present.

In March, 1910, the Baltimore Department of Health started preparing vaccine for use in hospitals, and in the early summer of 1911 the State Department began distributing it to any of its various institutions desiring to use it. About two years after the first anti-typhoid vaccine was distributed, the city decided to supply it to any of its citizens, and a few months later the State did likewise. The announcement has been made to every doctor in Baltimore and is still being made, appearing on the front cover of the monthly report. There is, of course, the possibility that this has escaped the notice of some physicians, and it is partly with the hope of bringing it to the attention of these that this paper has been written. Up to June, 1912, 2700 complete doses had been issued, and since that time 1742 more have been sent out by both city and State. Of the total number the State Department has issued 3375 and the city 1069 doses. Since the first of the year they have distributed 1824 and 744 complete sets, respectively. Of those issued since the first of June nearly 500 have been used in hospitals and other institutions; so that in the past five months about 1100 civilians have been inoculated, 600 of whom live within the corporate limits of Baltimore.

All things considered, it is probable that the present status of anti-typhoid vaccination in Maryland is all that could be expected for a procedure so recently instituted. Its further extension is largely dependent upon the interest the general practitioners display in the matter, for they are in more intimate contact with the people than any public official or department, and therefore can influence larger numbers of people to be vaccinated.

We have received reports of the character of the reaction following the injections in somewhat more than half the cases. In a considerable number of instances we have failed to get such reports, although specially printed blanks were sent out with the vaccine with the request that these be filled out and returned after the inoculations were completed. Strangely enough, this failure to send the information requested has occurred in the case of quite a number of institutions, though here the delinquencies have not been so numerous as among private physicians. As the records are not asked for from mere idle curiosity, we would respectfully urge all physicians using the department vaccine to send in these

*Read at the Semi-annual Meeting of the Medical and Chirurgical Faculty of Maryland at Cambridge, Md., November 12, 1912.

reports after completing the immunization. Those returned show a great preponderance of slight reactions and but few of a severe character. A larger proportion of those of a moderately severe nature has occurred among nurses than any other class.

In the hospitals of Baltimore there has not been a case of typhoid developing in any of the inoculated nurses and attendants, while of the uninoculated a number have had the disease. In one State institution, where the annual attack rate averaged about 100 in 10,000 for five years preceding the introduction of this method of prophylaxis, none of the immunized have had enteric fever, while the morbidity among the other inmates has remained the same.

No official report has been made to the department of any cases occurring in vaccinated civilians. By a somewhat circuitous route we have heard of two immunized persons developing typhoid, and in both instances it was bruited that the doctors blamed the disease on the vaccine. Naturally we discounted the latter part of these rumors, for such an assertion is too utterly foolish for a physician to make. For Castellani[1] has inoculated a number of persons with attenuated live cultures, at first using virulent baccilli; later a non-virulent culture. At one time he employed doses of 0.5, 1 and 1.5 c.c. of a broth culture which had been heated to 50° C. for one hour, but lately he has given a preliminary inoculation with dead bacteria followed one week later by 1 c.c. of the attenuated live culture. Again, Metchnikoff and Besredka[2] have immunized 745 persons with a sensitized culture of living organisms without any ill effect. All the vaccine issued by the city and State is heated at 56° C. for one hour and carefully controlled by cultural and animal tests.

We know very little concerning these cases. In one we heard the man went to bed immediately following the third dose and recovered, and was out within three weeks. This looks as though he had been infected prior to or very early in the process of immunization. Of the second we have heard that the patient—a physician—was sick in bed only a short time, but had been walking about for two weeks prior to this with a fever. We have no authentic information as to whether this fever developed before or after the vaccination was completed.

The carelessness on the part of the attending physicians in not making blood cultures from these cases unfortunately leaves some doubt as to whether they were really typhoid infections. In such instances a positive Widal means nothing. In order to illustrate how wrong impressions may be conveyed by cases like these we will cite the following example:

In the latter part of August, two cases of typhoid fever developed in an institution that is situated a few miles outside of Baltimore and contains about 110 inmates. The physician in

[1] *Lancet*, August 21, 1900, p. 528.

[2] *Semaine Med.*, July 24, 1912, p. 355. Quoted from editorial, *Jour. Am. Med. Assoc.*, Aug. 24, 1912.

charge promptly applied for vaccine, and on September 1 started to vaccinate the other inmates, the immunization of the whole institution being completed on September 17. During the first week of September two of the inmates who had received one dose of the vaccine developed fever. The following week two others, one having received one dose and the other two doses, were likewise stricken. Between September 19 and October 19 six others were attacked, all of whom had been completely immunized. The diagnosis of typhoid fever was made in all of these cases by the resemblance of the early symptoms to those of enteric fever, and from the fact that specimens of blood sent to the bacteriological laboratory gave positive Widal tests. However, all were characterized by extremely mild symptoms and were of short duration. In one case the temperature returned to normal on the fifth day and in two others on the tenth day, the longest persisting 25 days and the average for all 10 cases being 16 days.

At first it was believed that the earlier cases might have been infected prior to the inoculations, but the development of others six weeks after the immunization had been completed ruled out this theory. Next the question of the so-called negative phase following the injections was brought up, but since many experiments have shown that the doses used in immunizing against typhoid do not produce a negative phase, this was also discarded. Finally, cultures were made from the blood, urine and stools of a number of the patients and a careful examination made for the typhoid and para-typhoid bacilli. No typhoid bacilli were found, but bacillus paratyphosus alpha was isolated from eight cases, and the blood of each of the 10 patients gave a strong positive agglutination at high dilutions with this organism.

We are therefore convinced that while the two first cases were probably typhoid fever, the 10 developing later were paratyphoid fever. Several valuable points are to be gained from this investigation. First, the prompt immunization probably prevented an epidemic of typhoid fever in this institution, owing to the presence of the disease on the premises and the lowered resistance of at least 10 of the inmates. Secondly, the advisability of adding paratyphoid vaccine to the typhoid vaccine, thereby immunizing individuals against both diseases at the same time. Thirdly, that blood cultures should be made and carefully studied from all cases of fever following typhoid immunization, since hasty conclusions may be erroneous and lead to false impressions.

The advisability of adding the alpha and beta paratyphoid bacilli to our vaccine has long been considered. Recent analyses of cases seem to show that five to ten per cent. of the reported typhoid is in reality paratyphoid fever. This, together with the above-mentioned instance in which paratyphoid infection occurred in a number of individuals vaccinated against enteric fever, has

decided us to include both typhoid and paratyphoid antigens in the fresh stock we are preparing.

Our work during 1909 was done with a vaccine prepared from a number of strains in the laboratory, some of which had recently been isolated from the blood of enteric fever patients. As this gave a somewhat higher percentage of severe and moderately severe reactions than that used by the army, we decided to employ the same avirulent strain. This organism was sent to us through the courtesy of Major F. F. Russell. Early in the year of 1912 we returned to the polyvalent vaccine, using only avirulent organisms producing large quantities of antibodies. We felt that this would subserve its purpose better than a monovalent vaccine. The following facts led to this belief: Different strains of B. typhosus show varying degrees of sensitiveness to the antibodies contained in the same blood serum. Again, they vary in their capacity to produce the different antibodies. Lastly, Austrian's[1] experience with the ophthalmo-reaction in typhoid fever; this author found early in his experiments a patient that gave a negative reaction to an antigen made from a single strain, who later, when he had a relapse, gave a positive reaction. That this was not due to sensitization by the first instillation was shown by repeated failures in further experiments on normal individuals. He explains the phenomenon on the basis that the relapse was due to a different strain of B. typhosus which sensitized the patient to the particular antigen employed. This is in consonance with Durham's[2] explanation of infections in general. Since this time Austrian, therefore, has prepared his antigen from 80 different cultures of typhoid bacilli and has found the results to be far more constant.

The innocuousness of vaccination has long been established, no untoward results ever having followed in any of the tens of thousands of cases that have been inoculated. The following experience, however, may be cited as demonstrating how far the present doses are within the margin of safety:

In one institution the doctor in charge of the immunization accidentally gave to about 20 of the inmates 10 times the amount recommended; that is, instead of injecting 250,000,000 organisms at the first dose, he gave each of them 2,500,000,000 dead typhoid bacilli. He stated that no serious results ensued, although several had a somewhat severe reaction.

In conclusion, we feel that all physicians, nurses and attendants in hospitals should be advised to submit to vaccination against typhoid fever.

Further, we are firmly convinced that public institutions will find this measure useful in preventing both sporadic and epidemic cases; while finally, it is our belief that under existing conditions, all citizens should be advised, nay strongly urged, to be immunized,

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[1]Austrian, *Johns Hopkins Bulletin*, 1912, xxiii, 251, p. 1.
[2]Durham, *Jour. Path and Bact.*, 1901, vii, p. 248.

especially those particularly exposed to infection, such as physicians and nurses in general practice, commercial travelers, those brought intimately into contact with sewage or sewage-polluted waters, those living in temporary camps or under insanitary conditions, and those going to summer resorts.

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THE PRINCIPLES AND PRACTICE OF OBSTETRICS. By Joseph B. DeLee, A. M., M. D., Professor of Obstetrics at the Northwestern Medical School; Obstetrician to the Chicago Lying-in-Hospital and Dispensary; and to Wesley and Mercy Hospitals; Consulting Obstetrician to Cook County and Provident Hospital, etc., etc. With 913 Illustrations, 150 in colors. Philadelphia and London: W. B. Saunders Company, Baltimore: The Medical Standard Book Company. 1913. Cloth, $8.00 net. Half Morocco, $9.50 net. Large Octavo of 1060 pages.

It has been some time since we have come across a book which has so struck our fancy. Its arrangement is ideal, the illustrations numerous, well executed, true to nature and a material aid to the text, the type bold and clear, the English simplicity itself and perfect in style. Perhaps the book appeals so strongly because controversial points are avoided and the point at issue driven home dogmatically. For student purposes this method of instruction seems to be the best, as students' minds do not seem capable of grasping two or three points of view and giving the right proportion to each. It takes illustrations in these times to make a high-grade book. In this book one will not be disappointed in the illustrations, most of them happily original and made under the direct supervision of the author.

The subject-matter is divided into four parts: The Physiology of Pregnancy, Labor and the Puerperium; the Conduct of Pregnancy, Labor and the Puerperium; the Pathology of Pregnancy, Labor and the Puerperium; and Operative Obstetrics. This arrangement permits of the easy adaptation to class-room purposes. After all, what the general practitioner demands is not so much of the historical development of the subject, but is more interested in the absolute status of the diagnosis and treatment. By eliminating all controversial points and the reduction of historical items to a minimum, the author has gained space for the fuller descriptions of operative procedure. His advice and suggestions on these lines show a wide grasp of the various operative methods in vogue. Each operation is described with as great brevity as compatible with a clear understanding. It is this feature of the volume as much as any other which should appeal to the critical student. The book is bound to leave its impress upon obstetrical literature. Wherefore it gives us the greatest pleasure to recommend it to the kindest consideration by the medical fraternity.

# THE RELATION THE COUNTRY DOCTOR SHOULD SUSTAIN TO OUR CITY CLINIC.

By John D. Blake, M.D.

*Mr. President and Gentlemen:*

Realizing that the time alloted me today would necessitate my being brief, I will content myself by simply mentioning a few of the advantages to be derived from the relation the country doctor should sustain to our city clinics.

To my mind the bond of union between the city and country physicians should be so close and strong that the advantages accruing to the city physicians by virtue of their environment, which permits them to specialize along certain lines, should be placed at the disposal of the country doctors, and the country doctors should not be at all backward in taking advantage of them.

Indeed, I will go further and say, that in my judgment the country doctors have a right to demand of those of the profession who are connected with hospitals and colleges, and of those classed as teachers and clinicians, the privilege of attending lectures, clinics and laboratories.

The country doctors should so order and arrange their work at home as to permit of their spending from two to four weeks in the city each year, which would enable them to visit and attend the various lectures and clinics, as well as observe what is going on at the bedside in hospitals and in the hospital laboratories, and by so doing keep in touch with the medical and surgical advances of the day. Such a change would not only have the effect of benefiting the doctor, physically and mentally, but would be of great value to his patients. It would make him a better doctor by enabling him to be up-to-date in all that pertains to medicine and surgery. The clinical advantages of our city institutions should not only be placed at the disposal of the country doctors, but they should be so placed free of all cost to them. For it is to them that the clinicians look to a great extent for patronage and professional support in every way.

In practically every hospital in the city, the various counties are represented by one or more patients sent by the country doctors to be treated, thus furnishing much of the material that is so helpful to the clinician in his work of teaching and observation. This alone should entitle the country doctors to all the advantages of our clinics.

The country doctor who makes a slave of himself and by so doing becomes a mere automaton, confining his observations to his own limited practice and reading, makes a great mistake, and he and his patients must suffer proportionately as a consequence.

I am aware of the fact that the country doctor too often feels that an ill case, or an expected confinement, prevents his leaving

home for fear of incurring the displeasure of patient and relatives, and he argues that he cannot afford to lose their good will and practice; but I am sure when a community in which a doctor resides learns that he has gone away in order that he may better equip himself and become a better and more advanced doctor, and such advancement will redound to their benefit on his return to his work, that instead of protesting they will gladly second his determination in this direction and give him larger and more lucrative work.

Dr. William J. Todd has shown that there were in the State of Maryland, in 1910, two thousand and fifty-one (2051) physicians. Of that number there were 1158 registered in the city of Baltimore, leaving 893 which represented the counties of Maryland at that time.

There were at that time 1017 members of the Medical and Chirurgical Faculty. Of this number 515 were residents of the city and 502 were residents of the counties. Thus showing that 56 per cent. of the country doctors were members of the State faculty, while only 44 per cent. of the city physicians were members of the same. "These figures," says Dr. Todd, "show that while there are more physicians in the city than in the counties of Maryland, there is more interest shown by the country doctors in the welfare of the profession than by the city physicians.

Since it is a fact that in nearly every move that is made for the advancement of the profession by the city members, and in every effort that is made to increase our teaching and hospital facilities, when we desire to improve and render more efficient our State laws pertaining to the profession, and, indeed, in every great effort that is made by the city physicians, our country brethren are called upon to assist in such effort, and our experience has been that when so called upon they are practically never found wanting. In these and a thousand other ways the country doctors are a distinct help and advantage to the clinician and teacher in the city.

Why then should not the country doctors be entitled to such post-graduate advantages as our schools and hospitals afford and they desire?

I would like to see our city society laws so changed as to place the name of every country doctor who so desires and makes application therefor on the mailing list of such sections as he may request, and be notified by the secretary of their meetings.

This would enable many country doctors, especially those living near the city and those coming from a distance to the city for other purposes, to so arrange as to enable them to attend and take part in the proceedings of our various sections. Such an arrangement as this would, in my judgment, be highly satisfactory and mutually beneficial.

# MEDICINE TODAY.

*By E. Kilbourne Tullidge.*

To the many new and startling papers regarding research discovery that are now constantly seen in the various medical journals, there is usually but one comment by the long-established, well advanced, conservative medical man, *i. e.*, "wonderful," or marvelous. Again and again the thing recurs, and again and again the same reply is given. But to the young man with time, opportunity and laudable ambition there should be a natural tendency to take hold of and develop the new idea that attracts, and to see in it a possible advantage that may prove revolutionary, that may prove beneficial to the many ill and unfortunate. If the old practitioner is luke-warm, protests, is not convinced, but clings firmly to the faith acquired after many years of constant application, his testimony is bound to be far from rational. He prefers to abide by the drugs, applications and methods that have been tried and utilized with apparent success for many years back, and is reluctant to grasp at the few new findings coincident with the strides of advancement. He puts them aside or slurs them over with a "probability," until finally they are lost sight of entirely, or if still made use of by a few, may almost be considered fresh discoveries in time, when in reality they are of ancient date and are revivified merely by the trust of a few physicians. Although the body of man, despite physiology, does not essentially differ in function every few years, granting that it goes through certain well-known changes, many new conditions have developed in it, and many new diseases need treatment. Old methods have been revised and new ones substituted. Physiologists have found new physiologic phenomena, surgeons new operative conditions, pathologists amazing morbid, new lesions, bacteriologists new culture-growers and tissue-feasters. In fact, everything and everybody has changed to some extent. Old ideas have grown cold and new ones taken their place in heated discussions. The young graduate has become more curious; he no longer accepts things as stated facts, but asks the why and wherefore; in other words, he has commenced to develop those highly sensitized organisms allotted him. The foregoing, and much that might be added, should be taken to heart and make us willing to investigate new ideas and findings. How can we possess a trustworthy remedy that will throttle contagion or infectious disorders of divers sorts if we fail to look for it?

In so doing we should not by any means abandon those remedies of long standing that have already proven innocent and useful. It is the quality of mind that makes the bold surgeon risk the life of a patient in order that new and greater things may be proven accomplishable, and that many others may prolong their days. Credit should also be extended to the many who operate for explanatory purposes in order that the diagnostician may accurately

tell the precise locations and involvement of the lesions and of their every relation and complication.

It is, I am sure, generally accepted that the one explanation of the wide extent of quackery and sluggishness in the advancement of medicine is a lack of perfect research work. Every institution of medical learning should have installed in some capacity appliances and apparatus for use in such work.

The science of medicine is too intricate a subject of knowledge to be possibly studied in four years. It is ludicrous to think that a body of old and experienced practitioners should expect from young men of only four years' study, with but practically an introduction to the subject, knowledge equal to that gathered by themselves after many years of experience. What must be the result? It can take on no other aspect than that of stuffing a bag with paper. Five years at least should be devoted to a medical course, and one year of hospital training made compulsory in addition. A nearly ideal course is given by some institutions where the last two years of the five-year course may be spent by the student in pursuing those particular branches or subjects that most appeal to him, those subjects in which he is most interested and which after hours of toil he is sure to practice with a zest of enthusiasm. He does not thus leave college with no fixed idea of how to practice a science which is a most vital one. He has not the one motive of the almighty dollar, he sees further into his work than the man with the mere smattering, he sees an aim other than the golden lure.

Thus we have quackery at an ebb, and the subject Medicine begins to expand more broadly than ever before. New cures are found, new causes discovered, new preventives propagated. new people develop more healthy and robust than before, and finally a revolution exists, a revolution in the science of medicine, in the science of all things.

Recall the discoveries of recent years and of their benefit to humanity, the antitoxin of diphtheria, the vaccines of smallpox, and typhoid fever, anti-tetanic serum, cerebro-spinal meningitic serum, strepto, and staphylococcic vaccines, Salvarsan and many others.

Recent experimental science has brought with it many problems of intense interest and possibly of great and lasting value if solved correctly, but their importance to the race, indeed to humanity everywhere, largely depends upon the influence of the broad, judicial mind which is now more than ever required to separate the wheat from the chaff, always to the best advantage of fellow-men and women.

To whom does the highest praise belong? None so truly as to the thorough, resourceful, stick-to-itive physician ever ready to extend a helping hand and grasp the new shred that may be of advantage to his fellow-beings.

He it is that stands at the very top, and who, like Moses on Mount Pisgah, gazes at the promised land beyond.

# *Book Reviews.*

New Aspects of Diabetes, Pathology and Treatment. By Professor Dr. Carl von Noorden, Professor of the First Medical Clinic, Vienna. Lectures Delivered at the New York Post-Graduate Medical School, New York. New York: E. B. Treat & Co. 1912. Cloth, $1.50 net.

Every day more and more attention is being devoted by the medical profession to the problems of metabolism. It has taken a long time for the profession to come to a realization that many of the obscure maladies are in all probability due to faulty digestive processes, and that much good can be accomplished for our patients by scientific dietetics. Today, however, the order of yesterday has been completely reversed, and numbers of observers are giving much time to the elucidation of these questions. Amongst these workers is Professor von Noorden of Vienna, whose studies in the physiology and pathology of nutrition have opened up many promising avenues of research, which promise fruitful results. When one looks at the dietary advice as printed in books of days gone by one is forcibly impressed of the utter lack of any appreciation of the basic facts underlying the principles of rational feeding, and even now one marvels at the lack of interest displayed by the profession in general concerning a better understanding of feeding in nutritional diseases. The labors of such men as the author are, however, beginning to have some effect, and one notices a beginning awakening of the general practitioner to the importance of perfecting himself in the methods of modern dietetics. Of what earthly use is the advice to a diabetic to abstain from carbohydrates unless it is known how much and what kind of sugars the patient can metabolize? As a matter of fact, complete withdrawal of the carbohydrate element in the diet is often productive of more harm than good.

The book before us, though of few pages, is pregnant with advance knowledge concerning the pathology and treatment of feeding in diabetes, and represents the personal observations and conclusions of that master-mind, Prof. Carl von Noorden.

The writer justly states that the profession must not lose sight of the fact that, in addition to carbohydrates, under certain conditions proteins and fats contribute to the formation of sugar. In speaking of the treatment the author says: "Each year brings further knowledge, and shows that with dietic therapy successes can be obtained which are unequaled by any other form of treatment in the diseases on internal medicine. We must certainly neither forget nor neglect to give an adequate attention to the wonderful aids yielded by bacteriology, serology, opotherapy. All these methods, however, are limited in their applications; dietetics, on the other hand, play a part in all forms of disease and extends into every aspect of internal medicine. Modern dietetics may be

regarded as an offshoot from researches upon metabolism; both are intimately connected. I am proud, as one who has made many contributions on this subject, to realize that dietetics is now recognized as a fruitful branch of scientific medicine, although at one time it was a little-known and neglected stepchild which the practicing physician, but not the scientific worker, cared for."

One cannot but help being duly impressed, after reading the pages of this little book, with the immense time and labor expended by the author in clearing up mooted points and outlining a proper dietary regime. It is also a great satisfaction to know that you have been spending your time with one who is not rehashing the literature, but is giving something new; is leading you into practically untrodden paths, and withal in language so simple that a child could understand the message the writer desires to impart.

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MEDICAL MEN AND THE LAW. A Modern Treatise on the Legal Rights, Duties and Liabilities of Physicians and Surgeons. By Hugh Emmett Culbertson of the Ohio and New York Bars; Contributing Editor of the Laning (Ohio) "Encyclopedic Digest," "Notes on the American Decisions and Reports," and many other legal publications. Philadelphia and New York: Lea & Febiger. 1913. Octavo, 325 pages. Cloth, $3 net.

From remote times the practice of medicine has been regulated by law to greater or less extent, with occasional intervals of reaction, caused by class effort, to use the public statute for private gain. Modern medical practice cannot be said to have properly commenced in England until the beginning of the sixteenth century. In 1511 was passed the first statute for regulating the medical profession, that of 3 Henry VIII, cap. 2. By the statute of Henry the profession was for the first time divided into physicians and surgeons. Numerous acts of Parliament touching the medical profession have been passed since those days. It is with these and the laws enacted by the colonies and their successors, the States, that this book deals. When one thinks of the many pitfalls besetting the physician, of the many unjust accusations of one sort or another with which he is accused, of his duties to others, and, conversely, others to him, one is indeed amazed that schools pay so little attention to the legal aspects of medicine. In the mad rush to obtain practical knowledge concerning disease the legal rights of the doctor are entirely overlooked. This should not be, as constantly questions of law concerning the doctor are being raised, and he should be in a position to know his rights. In order to familiarize the profession with the modern law pertaining to medicine the author, by careful selection, has brought together under one cover all that is of substantial present importance. The volume is unique, there being nothing just like it, and should be and is of personal interest to every physician in every branch of

the art of healing. It deals with the duties, rights and liabilities of the professional man toward the public as settled by law, and also the legal rights of the regular profession to practitioners of the many schools of healing now in vogue, as well as the status of such healers in the eye of the law.

The diction is simple, the style clear and concise, and the text as far as possible expunged of technical terms. A reasonable knowledge of what is in this book may upon occasion prevent the doctor humiliation and embarrassment. At any rate, it will serve to direct the attention of the profession to a much neglected aspect of medicine. Every physician should have a copy on his bookshelf so that it will be ever at hand for consultation and advice.

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Diseases of the Heart and Aorta. By Arthur Douglass Hirshfelder, M. D., Associate in Medicine, Johns Hopkins University. With an Introductory Note by Lewellys F. Barker, M. D., LL. D., Professor of Medicine, Johns Hopkins University. 344 Illustrations by the author. Second Edition. Philadelphia and London. J. B. Lippincott Company. Cloth, $6.00 net. 1913.

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The Labyrinth. An Aid to the Study of Inflammations of the Internal Ear. By Alfred Braun, M.D., New York, and Isidore Friesner, M.D., New York. With 50 figures in the text and 34 halftones on 32 plates. New York: Rebman Company. Cloth, $4 net. 1913.

Though the study of labyrinthine disease is still in its infancy, great progress has been made, and much of which was only a surmise little more than yesterday is today accurately understood. The turtle-like encasement of this portion of the ear has doubtless done much to prevent a better understanding of its disease processes. But gradually, one at a time, a basic fact here and another there has been definitely determined, so that today quite a mass of absolute facts has been brought together, and in view of the interest displayed by the profession, especially the otologists, in a better acquaintance with labyrinthine affections, a book on the subject is indeed timely. In those topics explainable by two or more hypotheses the authors have selected that one which seems to them most reasonable, thereby saving valuable space as well as avoiding befuddling the reader's mind. The book is of some 240-odd pages, and thoroughly and systematically treats of the anatomy, physiology, methods of examination, pathology, symptoms of labyrinthitis and treatment of labyrinthitis. It is freely illustrated with original cuts from preparations made by the writers. Undoubtedly with a better knowledge of the anatomy and morbid processes, as well as symptoms of disease of the labyrinth, the profession will come to realize that disorders of this portion of the ear are more fre-

quent than heretofore believed, and it is such works as the one before us which will play an important rôle in directing the attention of practitioners to the recognition of labyrinthine disorders. The book is well written, and the authors are to be congratulated upon such a noteworthy addition to medical literature.

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A Textbook of Ophthalmology. In the Form of Clinical Lectures. By Dr. Paul Roemer, Professor of Ophthalmology at Greifswald. Translated by Dr. Matthias Lanckton Foster, Member of the American Ophthalmological Society; Member of the American Academy of Ophthalmology and Oto-Laryngology. With 186 illustrations in the text and 13 colored plates. Volume II. New York: Rebman Company. Cloth, $2.50 net.

It is seldom that we see in American literature such an admirable translation. Dr. Foster seems to have thoroughly grasped the ideas of Professor Roemer, and has handed them to us without apparently losing a bit of the force of the original. The book is eminently practical and will rank high among the textbooks of ophthalmology. The present volume deals with "Diseases of the Eyelids," "Injuries of the Eye," "Diseases of the Vitreous," "Diseases of the Sclera," "Diseases of the Lachrymal Organs," "Diseases of the Orbit," "Glaucoma," and "Musculature or Concomitant Strasbismus." No greater praise can be bestowed upon a publication than designating it a standard work, such is Rœmer's contribution to the literature on ophthalmology. It is eminently practical, well illustrated and a mine of useful hints not only to the specialist, but also to the general practitioner. The beauty of the work consists in the brevity and concisement of statement without slurring of the subject under consideration. This feature is very valuable to the general practitioner, as it allows him to become fully aware of the knowledge of the subject under investigation without the loss of valuable time. Taken from every aspect it will be found a very indispensable book and one which should be upon the book shelf of every practicing physician.

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The Surgical Clinics of John B. Murphy at Mercy Hospital, Chicago. Volume I, Number 6. December, 1912. Published Bi-Monthly. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Company. Paper, $8.00 per year. Cloth, $12.00. 1912. Octavo of 153 pages. Illustrated.

Amongst the subjects discussed in the present number are: Carcinoma of the breast; improvements in the treatment of malignant tumors with radio-active substances; salpingitic-pelvic infections; metastatic gonorrheal arthritis of the knee; ankylosis of the elbow-arthroplasty; ununited fracture of the femur; fracture of the internal semilunar cartilage;

ununited fracture of the humerus; ankylosis of the temporomaxillary joints. Here, as in some of the preceding numbers, a great deal of attention is bestowed upon bone surgery, and as it is in this line that Doctor Murphy has lately been bestowing much of his thought and endeavors, through these clinics, the profession is enabled to keep pace with his very latest work along these lines. Indeed in this very number one can get about as good a resume of recent bone work as can be found in the literature. The beauty of the volume is in the fact that each article is of such length as to permit the surgeon in a very few minutes to obtain a clear conception of the literature on the subject under discussion. Surgeons can ill afford to be without the Clinics within easy reach; in fact, the physician will find much of benefit in them.

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Muscle Spasm and Degenerations in Intrathoracic Inflammations. Their Importance as Diagnostic Aids and Their Influence in Producing and Altering the Well-Established Physical Signs; also a Consideration of Their Part in the Causation of Changes in the Bony Thorax. And Light Touch Palpation: The Possibility and Practicability of Delimiting Normal Organs and Diagnosticating Diseased Conditions Within the Chest and Abdomen by Very Light Touch. By Francis Marion Pottenger, A.M., M.D., LL.D., Medical Director of the Pottenger Sanatorium for Diseases of the Lungs and Thorax, Monrovia, Cal. Sixteen illustrations. St. Louis: C. V. Mosby Company. 1912. Cloth, $2 net.

The material in this monograph represents three years' original observations and practical suggestions deduced therefrom, as based upon several thousand physical examinations. If the methods are as successful in the hands of others as in the author's, the technique of physical diagnosis as it concerns the chest will be materially renovated. He lays especial stress upon the changes occurring in the muscles of the chest and apex in arriving at an early diagnosis of tuberculosis. The burden of the booklet is that inspection and light palpation when intelligently employed will give the clinician as much, if not more, actual knowledge of intrathoracic changes as percussion and auscultation, upon which the profession now rely for such information. Pottenger states, and justly so, that inspection and palpation have not been developed to their fullest extent, which inefficiency is due to the difficulty in acquisition. He is firmly of the opinion that by these methods alone one can determine more or less accurately whether or not disease is present in the chest, whether or not it is active or quiescent, also its extent. When used in conjunction with auscultation and percussion he has found them most valuable adjuncts. If upon more thorough trial the conclusions of Pottenger prove erroneous, still his labors will not have been for naught, as his

contribution will have focussed attention upon inspection and palpation as aids to intrathoracic diagnosis.

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INTERNATIONAL CLINICS. A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene and Other Topics of Interest to Students and Practitioners. By Leading Members of the Medical Profession Throughout the World. Edited by Henry W. Cattell, A.M., M.D., Philadelphia, U. S. A. With the collaboration of William Osler, M.D., Oxford; A. McPhedrab, M.D., Toronto; Frank Billings, M.D., Chicago; Charles H. Mayo, M. D., Rochester; Thomas H. Rotch, M.D., Boston; John G. Clark, M.D., Philadelphia; James J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh; John Harold, M.D., London; Richard Krety, M.D., Vienna. With Regular Correspondents in Montreal, London, Paris, Berlin, Vienna, Leipsic, Brussels and Carlsbad. Volume 2, twenty-second series. 1912. Cloth, $2 net. Philadelphia and London: J. B. Lippincott Company.

The present volume of International Clinics maintains the same general excellence in quality and selection of articles as its predecessors. Something good and useful is to be found in each sub-division of medicine with which the book deals. In fact, it will be found a veritable fund of advance information to the general practitioner. Though all of the articles are of the highest order, perhaps the general reader will be most interested in those dealing with our tropical inheritances, pellagra and beriberi. Heiser, in writing on beriberi, states that this malady in the Orient may be said to be what yellow fever was in the Southern part of the United States, the West Indies and South America before the discovery of the manner in which the disease was transmitted, only beriberi is much more destructive to life and responsible for a vastly larger number of deaths.

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GOLDEN RULES OF SURGERY. Especially Intended for Students, General Practitioners and Beginners in Surgery. By Augustus Charles Bernays, A. M., M. D., Hdlbg, M. C. R. S., England; Life Member of the German Society for Surgeons of Berlin, Chief Surgeon Lutheran Hospital and for Twenty Years Professor of Anatomy and Surgery in St. Louis, Mo. Second Edition, Revised and Rewritten. By William Thomas Coughlin, M. D., Assistant Professor of Surgery, Chief of Clinic, St. Louis University Medical School, St. Louis, Mo. 1913. St. Louis: C. V. Mosby Company. Cloth.

Golden Rules of Surgery is a small volume devoted to the essentials of the art and science of surgery. The important facts of

surgery are here set forth in abbreviated form. The essentials of surgery are condensed to the point where further condensation would render the volume valueless. It is this brevity and conciseness of statement which gave the first volume its universal popularity, and we are glad to note that the present edition retains this important feature, without the loss of any of the force or poignancy of its predecessor. It was this feature that gave the first edition of Bernay's book its great popularity, and it will be the means of retaining the same for the present edition. The field of surgery is admirably covered for a book of its character. Those points which have been found of value to the writers and only mentioned in a more or less casual way, or not at all in the larger books, are here set forth clearly and succinctly for the benefit of the reader. As a prelude to the further study of surgery students will find much valuable material and many useful hints and directions in this little volume. Here is an ideal example of multum in parvum.

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Surgery of the Brain and Spinal Cord. Based on Personal Experiences by Professor Fedor Krause, M.D., Geh. Medizinalrat Dirigierrender Arzt Am Augusta Hospital Zu Berlin. English Adaptation by Dr. Max Thorak (Rush Medical College, University of Chicago), Surgeon-in-Chief American Hospital, Chicago, Ill.; Consultant Cook County Hospital, Chicago, Ill.; ex-Professor of Surgery, Bennet Medical College (President Loyola University), Chicago, etc., etc. Volume III. With 42 Figures (three of which are colored) in the text, and 47 colored figures on 22 plates. New York: Rebman Company. Cloth, $7 net. 1912.

Amongst the observations recorded and fully described in volume III are neoplasmata at the base of the skull, neoplasmata of the Gasserian ganglion, prognosis in extirpation of neoplasmata of the brain, intracranial suppurations, metastatic processes, injuries of the brain, opening of the vertebral canal by laminectomy (including position of patient, preparations, dressings, course), tumors of the spinal membranes, intramedullary neoplasmata, neoplasmata and tuberculosis of the vertebral column, injuries of the spinal cord, etc.

By specialists abroad Krause is recognized as a surgeon of the first water, therefore his contributions are eagerly sought by the reading profession. Careful study of his "Surgery of the Brain," as rendered into English, only serves to strengthen this impression. The translator deserves great praise for the accurateness with which he has rendered the original text into English, the translation being remarkably good. We hope that a generous reception will be accorded this volume, as it is a work of much merit and supplies a field neglected to a large extent by American authors.

# MARYLAND MEDICAL JOURNAL

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BALTIMORE, MARCH, 1913


## DISEASES OF THE HEART AND AORTA.

IN the mad rush to conquer the ravages of tuberculosis and cancer, the part played by heart affections in the toll of death has been to a large extent overlooked, both by the profession and the laity. It is therefore high time that our attention be directed to the part diseases of this organ play in the production of human infirmities, their causes, prevention, alleviation and possible cure. If we are to conquer heart affection, as in cancer, tuberculosis, etc., the disease must be recognized in its incipiency; in fact, nearly before symptoms have arisen, as after organic damage is once started, all that can be hoped for, with our present knowledge, is the holding of the process stationary. Perhaps the doubtful will ask, how are you to recognize heart lesions before they commence? The same question was propounded in the case of the two above-mentioned diseases, but thanks to the patient observations of careful investigators, certain rather indefinite symptoms when taken individually were valueless have been found when taken collectively to indicate the onset of serious trouble, so in heart affections, after further study it may be found that certain sensations portend the onset of cardiac troubles. At any rate, as such a large proportion of the death rate is directly attributable to one disease or another of the heart, their prevention should command the best thought in the medical profession. Certainly by proper medication, and especially dietary regime, we should, to a large extent, be able to prevent heart involvement. Here, as elsewhere in medicine, preventive medicine should be brought into play. An ounce of prevention is worth a pound of cure, is no truer a saying than in heart conditions. A work which should go a long way in calling the remissness of the profession to this class of sufferers is the second edition of Hirschfelder's "Diseases of the Heart and Aorta." We of Maryland should be particularly interested in this production, as it is a Maryland creation, the basis of the book being from observations made in the Johns Hopkins University.

It is needless to state that the present volume is the most complete single work on the subject in the English language. Here pure science and practice are brought together, their interrelation shown, and what benefits we are to look for from scientific investigation. Besides placing the subject before the reader in an agreeable manner, the contents show much patient thought and personal investigation. The book is a revelation in thoroughness. The very latest scientific appliances and the method of their application and the value to be placed upon their findings are accurately presented. The clearness and brevity of the presentation, the liberality of illustrations, the excellence of the arrangement, the experience of the writer, should appeal to the medical profession. Here, as nowhere else, is the reader able to find under one cover an epitome of the present status of cardiovascular diseases. The most critical will not be able to find a flaw in the manner in which the author has combined the most recent advances in cardiac anatomy, physiology, pathology and clinical observations, thus rendering it a book that both the scientist and the general practitioner can use with pleasure and profit. The electro-cardiograph, which has recently come into much favor with investigators, owing to the information which it has given on the mechanism of the normal and pathological heart beat, has been discussed in detail as to theory, construction and application. The book is divided into four parts: Part I dealing with General Considerations and Methods of Diagnosis, such as blood pressure, arterial pulse, venous pulse, X-ray examination, physical examination. Part II: Diseased conditions due to diffuse pathological processes, symptoms of cardiac disease, general principles of treatment of failure of the heart, the effects of drugs in cardiac disease, hypertrophy and atrophy, fatty deposits in and about the heart, affections of the myocardium, arteriosclerosis, vasomotor crisis and the angioneurotic lesions, sclerosis of the coronary arteries and angina pectoris. Part III: Diseased conditions due to localized lesions, endocarditis, mitral insufficiency, marriage, pregnancy and labor in cases of heart disease, congenial heart disease, heart-block or the Adams-Stokes syndrome, wounds of the heart, aneurism. Part IV: Functional diseases without anatomical lesions, paroxysmal tachycardia, thyroid heart, cardiac neurosis. The book has appealed to us as of such a meritorious character that we could not resist the temptation of bringing it more prominently before our readers by placing it in the editorial columns.

## Medical Items.

A daughter was born recently to Dr. Walton H. Hopkins, University of Maryland, '04, and Mrs. Hopkins of Annapolis.

Faustino Sarinas, a nephew of Aguinaldo, former chief of the insurgent forces in the Philippine Islands, is a student in the University of Maryland Medical School.

Rev. and Mrs. James R. Bridges of Charlotte, N. C., have announced the engagement of their daughter, Helen Venable Bridges, to James A. West, M.D., College of Physicians and Surgeons, '93, of Hancock, Md. The wedding will take place in the latter part of March.

Dr. Kenneth Jones, assistant in the insane department at Bayview, has resigned to take a similar position in another institution.

A portrait of the late Dr. Christopher Johnston will shortly be presented to the Medical and Chirurgical Faculty of Maryland. Dr. Johnston was president of the Faculty in 1886-1887. He was professor of surgery in the University of Maryland at the time of his death, and was the best-known surgeon in Baltimore.

Dr. C. F. Burnam will shortly give a lecture on radium and its uses in the amphitheater of the Johns Hopkins Hospital.

It is understood that friends and admirers of Dr. Louis McLane Tiffany are planning to present his portrait to the Medical and Chirurgical Faculty of Maryland.

The faculty of the College of Physicians and Surgeons announce three new appointments—two to the staff of instructors of the college and one physician to the medical staff of the hospital. Dr. William Greenfeld of the class of '09 has been oppointed full-time instructor in pathology; Dr. Thomas J. O'Brien, class of '12, of Providence, R. I., has been appointed assistant instructor in surgery. Dr. J. K. Pepper of North Carolina, class of '07, has been added to the medical staff of the hospital.

The medical library of the College of Physicians and Surgeons is being revised under the supervision of Dr. A. C. Gillis, superintendent of Mercy Hospital.

The engagement is announced of Miss Mary Louise West, daughter of Mrs. C. T. West of Baltimore, to Dr. Howard Martin Kemp, Baltimore Medical College, '11, of Turners Falls, Mass.

Dr. Nathan R. Gorter, recently appointed Commissioner of Health for Baltimore, to succeed the late Dr. James Bosley, had the misfortune to fall and break his right arm recently.

Dr. Andrew A. Anderson of the staff of the Mercy Hospital, has resigned, and will take up private practice in Salt Lake City, Utah.

There is an epidemic of measles in Annapolis.

A series of lectures on tropical diseases is being given at the University of Maryland. Among the lecturers are Dr. Rupert Blue, Surgeon-General of the United States Public Health Service; Dr. Henry R. Carter, superintendent of the Marine Hospital, Baltimore; Dr. C. W. Stiles of the Hookworm Commission of North Carolina, and Dr. James A. Nydegger of the United States Public Health Service.

Dr. D. F. Onnen is spending the winter in Florida.

Dr. Adolf Meyer, head of the Phipps Psychiatric Clinic at the Johns Hopkins Hospital, announces the formal opening of the Phipps building April 16. The following members of the staff have already been announced: Dr. Henry J. Berkley, University of Maryland, '81, clinical professor of psychiatry; Dr. Clarence B. Farrar, Johns Hopkins Medical School, 1900, associate in psychiatry; Dr. William Rush Dunton, University of Pennsylvania, '93, instructor in psychiatry; Dr. Edmund B. Huey, assistant in psychopathology; Dr. Trigant Burrow, University of Virginia, '99, assistant in psychopathology; Dr. David H. Henderson, University of Edinburgh, '07, assistant in psychiatry. Other announcements of members of staff will be made later.

The cornerstone of the Miners' Hospital in Frostburg was laid February 3, 1913.

Oil paintings of Drs. John Francis Monmonier and John Buckler have been presented to the Medical and Chirurgical Faculty of Maryland, the presentation addresses having been made by Drs. Eugene F. Cordell and Samuel C. Chew.

The engagement is announced of Miss Mary Chase King, daughter of Dr. and Mrs. John Theodore King, to Dr. James Payton Leake, Tulane University Medical Department, '01, Assistant Surgeon, United States Public Health Service, at present located in Washington, D.

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C., where he is doing research work in the Hygienic Laboratory. The wedding will take place in the fall.

Dr. John S. Fulton assumed his duties as secretary of the State Board of Health on February 1, 1913.

Dr. Edmund Burke Huey, a recent appointee to the staff of the Phipps Psychiatric Clinic, has gone to California for his health.

The Health Officers of Baltimore County have passed resolutions of regret on the death of Dr. Richard Massenburg, and ordered spread upon their minutes resolutions commending his work for the betterment of conditions in Baltimore county.

Dr. Lewis Mines Allen of Winchester, Va., is the guest of friends in Baltimore.

Dr. James D. Love of Jacksonville, Fla., formerly of Baltimore, announces to his friends in the medical profession that in future his profession will be limited to the diseases of children.

Dr. Charles Wellman Mitchell, who has been quite ill, is said to be much improved.

The schools of Chesapeake City and Aberdeen, Md., have been closed because of the prevalence of diphtheria in the neighborhood.

A committee, headed by Dr. Adolf Meyer, has been appointed by the Maryland Psychiatric Society to find out to what extent it will be feasible to remove patients from the State hospitals for the insane to homes where they can be made self-supporting.

Dr. Randolph Winslow, a member of the Judicial Council of American Medical Colleges, has returned home from the recent meeting of the association, which was held in Chicago February 24, 25 and 26. An important step was taken at this meeting, a fifth year being added to the curriculum of the colleges belonging to that association after January 1, 1914. Dr. R. Dorsey Coale, dean of the medical faculty of the University of Maryland, also attended the meetings.

Dr. C. R. Winterson of Hanover, Md., is laid up with a mild attack of grippe.

Drs. Frank Lynn, Robert P. Bay and John A. Tompkins will be in the Maryland contingent in the inaugural parade March 4.

Dr. Fielding H. Garrison of the Surgeon-General's Office, will shortly issue a book on the "History of Medicine," which will be published by Saunders.

## MARRIAGES.

Naaman J. Karragulla, M.D., College of Physicians and Surgeons, '06, and Lieutenant in the Egyptian Army, located at Mardin, Mesopotamia, Asiatic Turkey, was married in Baltimore on February 3, 1913, to Miss Stella Emily Toal of Baltimore. The couple will live at Mardin.

Joseph Tate Smith, Jr., M.D., Johns Hopkins Medical School, '07, of Cleveland, Ohio, to Miss Mary K. Hutchins of Baltimore, at Baltimore February 20, 1913.

William Herbert Pearce, M.D., University of Maryland, '91, of Baltimore, to Miss Sarah Frances Ferguson of Charleston, S. C., at Charleston February 4, 1913.

William Julius Mason, M.D., University College of Medicine (Richmond), 1900, of Norfolk, Va., to Miss Flora Mae Wilson of Girdletree, Md., at Baltimore, February 27, 1913.

## DEATHS.

Philip Hanson Hiss, M.D., Columbia University, '95, died at his home, 667 Madison avenue, New York, February 27, 1913, aged 44 years.

Samuel Brock Angle, M.D., University College of Medicine, '01, of Windsor, Va., died in St. Andrew's Hospital, Suffolk, Va., February 23, 1913, aged 32 years.

Hamilton K. Derr, M.D., University of Maryland, '81, died at his home in Hagerstown, Md., of heart disease, aged 61 years.

Griff T. Daily, M.D., College of Physicians and Surgeons, '84, died suddenly while calling on patients November 23, 1913.

Thomas Overton Meredith, M.D., Baltimore Medical College, '87, of Harrodsburg, Ky., died in Rochester, Minn., after a surgical operation, January 30, 1913, aged 49 years.

Clarence W. Zurcher, M.D., College of Physicians and Surgeons, '11, died at his home in Leetonia, Ohio, December 27, 1912, from scarlet fever, aged 25 years.

William L. Ziegler, M.D., College of Physicians and Surgeons, '81, died at his home in Steelton, Pa., January 20, 1913, from pneumonia, aged 57 years.

James W. Eichelberger, M.D., University of Maryland, '70, of Emmitsburg, Md., died in the Frederick City Hospital February 23, 1913, from Bright's disease, aged 71 years.

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# THE KNOWLEDGE OF THE NORMAL RATE OF PROGRESS OF THE INTESTINAL CONTENT AS AN AID IN THE DIAGNOSIS OF A COMMON FORM OF CONSTIPATION.*

*By Albert Hynson Carroll, M.D.,*
Associate in Gastro-Enterology, University Hospital.

WITHIN the last few years some new and interesting light has been shed on the subject of constipation. Very valuable information regarding the pathogenesis of the several varieties has been obtained, and we are now in a position to diagnose and to treat the condition less blindly than was formerly the case.

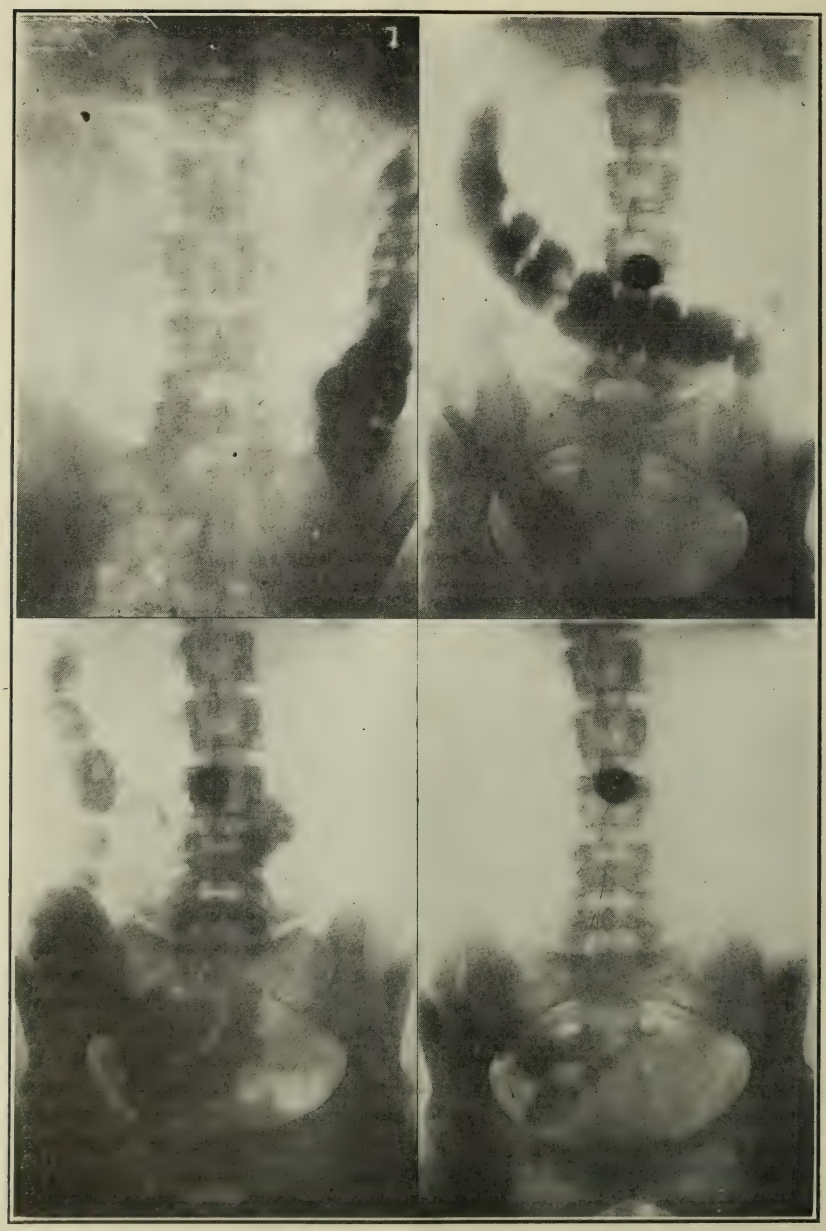
Until quite recently we were of necessity often content with giving the patient a certain amount of temporary relief. If a permanent cure was attempted, it was the rule rather than the exception for the patient or the physician or perhaps for both to lose confidence. The natural result was that many tedious but by no means hopeless cases continued to suffer, since the treatment was largely experimental.

In no other class of cases was this so frequently true as in those patients in whom there existed an atony of the intestinal musculature following overstretching of the bowel by feces and gas. A condition somewhat akin to congenital dilation of the colon—Hirschprung's disease. This inability to diagnose correctly was due to the fact that we did not know at that time the normal rate of progress of the intestinal content throught the tube, and we were unable to determine in just which anatomical division of the tube the *actual delay* causing the constipation occurred.

We knew how long it should normally take for ingested food to traverse the entire tract, the upper and lower ends of which are under the control of the central nervous system, while the movements of the remainder or central portions are chiefly determined by local mechanisms which are nervous in character.‡ We knew from the investigations of Bayliss and Starling that the onward propulsion of the contents of the intestinal tract was

*Extracted from a paper read before the University of Maryland Medical Society April 8, 1913.

‡This discussion is based on the assumption that 24 hours should elapse between complete defecations. If the patient was one who normally defecated every 48 hours, the fact should be ascertained in order to avoid error.



The upper righthand X-ray was selected to show the normal position of a meal at the cecum and in the ascending colon, about six to eight hours after ingestion. The upper lefthand one shows where the meal should be two hours later. The lower lefthand shows the meal in the descending and pelvic colon. The lower righthand illustrates the partial retention of feces, and was taken after the defecation of only a part of the content *distal to the splenic flexure.* In such cases examination usually discovers some fecal material in the rectum an hour or more before defecation. An evidence of atony.

brought about by rythmic wave-like peristaltic contractions of the walls of the tract as a result of the phenomena, that a wave of relaxation was followed by a wave of contraction.

What we did not know at all definitely was the length of time the content normally occupied before leaving the stomach and in reaching the cecum, in arriving at the hepatic flexure, the splenic flexure and in traversing the descending colon and on until it met the obstruction at the acute angled pelvi-rectal flexure.

An exhaustive investigation of this mechanical aspect of digestion was made by Arthur F. Hertz, working with F. Cook, A. M. Cox and others in 1907, at Guys Hospital, London.[1] He made use of the X-ray to study the rate of progress of bismuth laden meals, using healthy men, and was able to demonstrate that the time of arrival of the food residue at well-known anatomical landmarks was quite constant. He also studied in a similar way the journey of the contents in persons suffering from constipation. Finally, the progress was observed in both well and in constipated subjects after the administration of various drugs ordinarily used in the treatment of constipation.[2] By comparing the results obtained in this way with the clinical signs and symptoms, it was possible to recognize in very many cases, *using only simple clinical methods,* in just which part of the tract the delay was occurring.

This work is of great value, not only because of the deductions which were drawn from it, which aid so materially in interpreting the signs and symptoms of constipation as regards its correct diagnosis, but also because we are often saved the expense and inconvenience of having to have recourse to the X-ray. Once we are aware of the normal rate of progress, ausculation, percussion and palpation will, in a large measure, reveal to us if the progress is not orderly, and if there is *a delay* the location can usually be discovered.

Although the intestinal sounds arising from the passage of gas and food residue through the tube are very complex and generally beyond our interpretation, Cannon agrees with Hertz that there are distinctive sounds to be heard as the content reaches the ilio-colic valve and begins to pass into the cecum.[3] These characteristic sounds are heard four or four and a half hours after breakfast, and coincide with the first appearance of the bismuth shadow at this point. Previous to this appearance of the content at the ilio-colic juncture there is nothing to be heard with the stethoscope when placed over the cecum. This is definite information of decided value and interest.

A little later the cecum begins to fill, and there can be elicited a dull percussion note over the cecum with the subject standing, which will disappear on assuming a horizontal position, since the

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[1]Guys Hosp. Reports, p. 383., 1907.
[2]Proc. Soc. Med., Dec., 1908.
[3]The Mechanical Factors of Digestion. Cannon. Arnold. London.

fluid contents will then spread along the posterior wall. Two hours later the dull area has extended upward and has reached the hepatic flexure, and it does not change now to a tympanitic note on lying down. In about nine and one-half hours the content should pass the splenic flexure and begin its descent into the descending colon. This requires about two or two and one-half hours, and the content does not reach the pelvic colon until twelve hours after ingestion. The progress into and through the pelvic colon is slow, but this division of the canal should contain practically all the food residue of a given meal in sixteen hours. Photographs I, II, III illustrate the arrival of a bismuth meal at these anatomical positions or landmarks in the gastro-intestinal tract.

Hertz approached the subject of constipation and its interpretation from a new angle, recognizing that there are two quite distinct processes or journeys made by the contents of the intestine. These are: First, the passage of the food residue from the stomach to the pelvic colon, and second, the complete evacuation of the last division of the colon at proper intervals.

In the first, the passage of the food through the intestines may be delayed while defection may be normal, while in the second, the passage through the intestines may be normal in time, while *defection is delayed or incomplete.*

It is now accepted that at each normal defecation the colon is *completely emptied in all that portion distal to the splenic flexure.* If this portion is not completely emptied, it is usually due to a lacking of force necessary or to some obstructive condition. When this exists as a result of the lack of tonicity of the intestinal walls, in many instances there will be found some *fecal material in the rectum* an hour or more before the period arrives for the next defecation. Robert Barnes used the word "dyschezia"[4] (painful constipation) to denote very similar conditions, and Hertz has called this atonic type "dyschezic constipation" where the above-mentioned incomplete evacuation takes place.

Let us accept the following definition: "Constipation is a condition in which defecation is delayed or occurs at too infrequent intervals; or in which the feces are hard and dry; or in which the fecal material is too small in amount." It is evident that only one, or two, or all three of the conditions may be present at the same time, and that a delay in any portion of the tract will cause a lengthening of the proper period between defecations. Remember also that we can determine when the content has arrived at certain definite portions of the tract, and that there is or should be a complete evacuation of all the content distal to the splenic flexure at each defecation. If otherwise, the defecation is incomplete. If the stool is incomplete it is usually ascribable to atony. With such an atony there is a retention with the absorption of moisture and the feces becomes hard and dry, and in many cases some of it will be found in the rectum, which normally is empty until just before defecation, a phenomena demonstrated long ago by O'Beirne.

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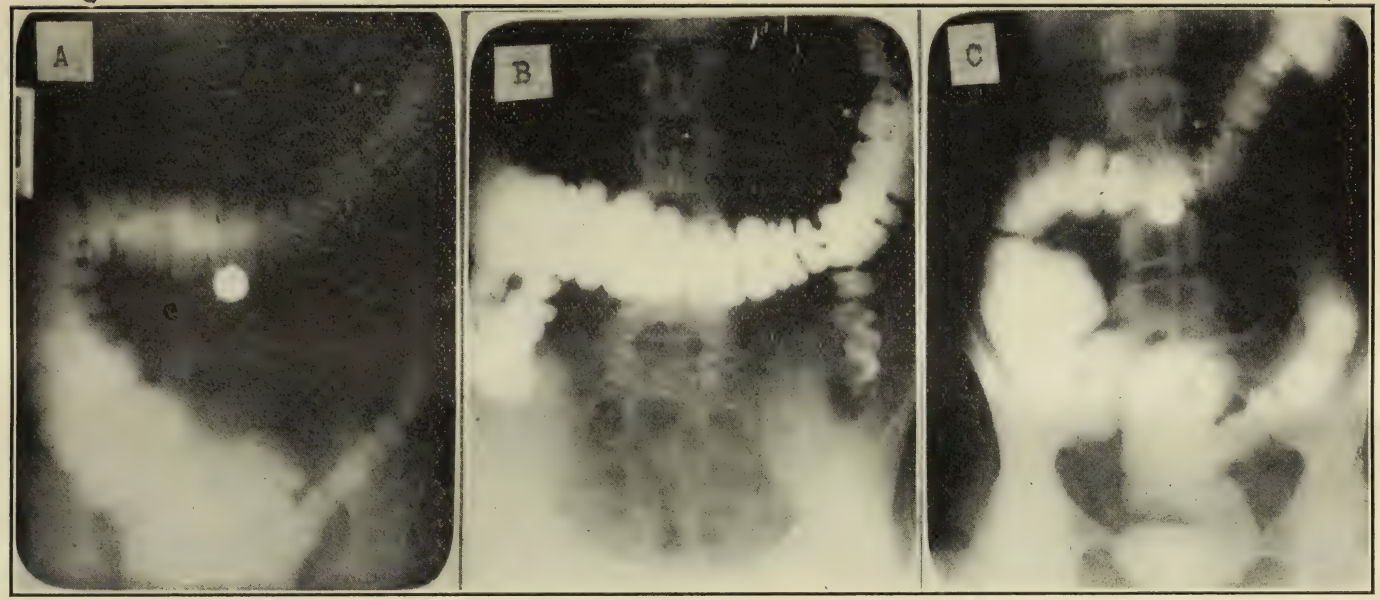
[4]Diseases of Women. Barnes. London. 1878, p. 145.




These three X-rays were selected to show "actual delay," occuring in three anatomical divisions of the colon.

A. Shows an enormously distended cecum, which is the point of "actual delay" in this case.

B. Illustrates a similar distention and a retention of content in the first part of the transverse colon, with a narrowing of the luman in its last third.

C. The delay in this case follows from a distended rectum and cecum, which may have been ascribable to either the first or the latter had either existed independently.

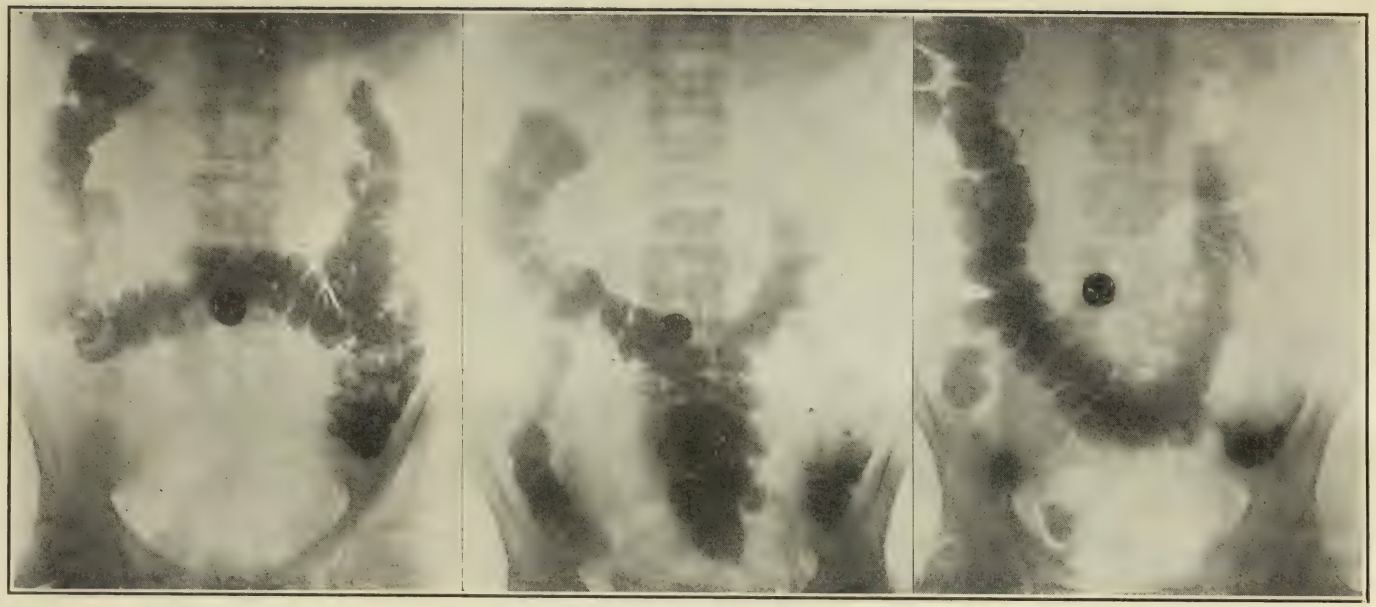
Let us follow an imaginary meal through a previously empty tract. Actual delay may take place in the stomach. Percussion or ausculatory methods will shed no real light, as a rule, but if the stomach is suspected as a primary factor, one or several meals can be aspirated with the stomach tube and its motility and the time of food retention be accurately determined. If the stomach is functioning properly, but the characteristic sounds are not heard in four or five hours at the ilio-colic region, the delay is of necessity occurring in the small intestine. A dull note should be heard soon after the appearance of these sounds, on percussing the cecum, which will disappear on placing the patient in the supine position. Two hours later the hepatic flexure should be reached and the area over the ascending colon will give a dull note, regardless of position. In several hours more this portion of the tube will no longer give a "dull note" if the hepatic flexure and the transverse colon is being normally invaded by the advancing meal. To discover, by either auscultation or percussion, if the passage through the transverse colon is progressing normally is usually quite impossible. The photographs No. 1, No. 2 and No. 3 illustrate how difficult it is, even with the X-ray, to locate the position of this portion of the gut at times, unless a series of pictures be taken. Again, its normal anatomical relationships prevent complete percussion or auscultation.

I have devised, however, a method meriting a certain amount of confidence which I have experimented with with fairly satisfactory results.

Hertz had demonstrated the emptying of the gut distal to the splenic flexure at each normal defecation. These experiments were carried out with the entire tract free from any food residue except what arose from a single charcoal-laden meal, and were inspired by Hertz's definition, that "Constipation is a condition in which none of a meal taken eight hours after breakfast is evacuated at the next defecation." These experiments verify the statement. Not waiting for 24 hours to elapse to discover if an "eight-hour-after" meal was found in the last part of the stool, I gave the subjects a high enema 11 hours after the test meal and observed if any charcoal-laden feces was immediately expelled. The method is well worth trying where time allows and the patient is willing, although its accuracy as a diagnostic aid is open to many just criticisms. * * *

The journey downward through the descending colon is a slow one, but the residue should reach the pelvi-rectal flexure in 14 to 16 hours.

As further additions occur to the mass, which is blocked at this acute angled flexure, the walls will become distended, the angle lessened and some of the mass enters the rectum. There is the call to defecate. As above mentioned, there is normally no



No. 1. No. 2. No. 3.

No. 1, No. 2 and No. 3 were taken from the same patient, and show clearly how the transverse colon may change position. Such a transverse colon cannot be located, and the progress of the content cannot be ascertained by percussion, palpation or auscultation. One X-ray alone would also mislead. In No. 2 there appears to exist adhesions binding the center of the transverse colon to pelvic viscera. No. 3 shows it to be merely redundant. Hepatic and splenic flexure adhesions appear to exist in No. 1.

fecal material in the rectum except just previous to defecation. If material is found to be there on digital or proctoscopic examination, there is excellent ground for believing that there is *an atony of the lower part of the tube* and that *complete evacuations are not taking place* of the content distal to the splenic flexure. Frequently the gut, laden with feces, can be palpated within the pelvis shortly after a defecation which was thought to be complete. * *

It is not my intention to cover all the methods in this short paper, but I have attempted to point out a few of them, which, if practiced generally, will prove of undoubted value as the practitioner becomes more skilled in these simple methods through the frequent use of them.

Plate No. 1: H. W.; Case No. 34.

Plate No. 2: H. W.; Case No. 34.

As an example, the X-ray photographs No. 1 and No. 2 were made in a constipated patient who was an exceptionally splendid physical specimen. There was a mild chronic gastritis, with a retention of food in the stomach due to an atonic condition which evidenced itself not immediately after ingestion, but which was discovered to come on about two hours after eating. The general health, notwithstanding the long duration of the trouble, was otherwise perfect. No explanation presented itself until it was discovered that although some of the gastric content, in fact most of it, left the stomach in good time, there was a *delay of several hours in the appearance of the sounds* of arrival at the cecum. A typhoid fever many years previously had left the adhesions seen in plate No. 1. The content was delayed in the end of the ilium. There

had never been an appendicitis or any abdominal pain. The blocking of the progress of the meal undoubtedly caused a distention of the ilium, and this was followed reflexly by a closure of the pyloric valve, although this blocking and distention did not cause any localized discomfort or pain to the patient.[5]

As regards atonic conditions of the colon: The colon is a very slowly-moving portion of the tube, and even the introduction of small amounts of food residue does not cause any material quickening of its inherent peristaltic movements. But when the walls have become distended there will be seen with the fluorscopic screen an acceleration of the movements of the entire tube. In the same way it has been shown that the *greatest stimulation to colonic peristalsis is the ingestion of food.*[6] There will be a greater onward march of food during the ingestion of a meal that has occurred during the three or four hours previous. Bearing this fact in mind, it will be quite clear why the hour following breakfast is the one to emphasize in teaching the patient to form correct habits.

I cannot close without again pointing out a few of the reasons for discouraging the use of drugs in the treatment of constipation of the atonic or dyschezic type. In this condition the last portion of the colon becomes in a way an internal privy, which has for its floor the pelvic-rectal flexure, and for its walls a muscular tube, plentifully supplied with nerve cells and lined with mucous membrane. If there is an undue retention, too great an amount of moisture is absorbed from the contents. Additions take place, and when the distention is sufficient the acute pelvi-rectal angle is lessened in acuteness and some feces enters the rectum. The call to defecate follows. This sets up an active peristalsis in the colon, and other additions are received from above.

What is the result? The walls are stretched and the vascular supply is interfered with. The mucous membrane may atrophy, the nerve cells are pressed upon and degenerative changes take place. Although the call to defecate may come, there is not sufficient strength of muscle cells or response from the nerve elements to bring about the expulsion of the dried-up and hardened mass. There is an atony accompanying atrophic changes.

What can be done to remedy this? We must first of all endeavor to bring about a return of the blood supply, and to rest the tissues. This can only be done if the pressure on the walls is removed. A daily enema will empty this portion of the tube and will bring this necessary rest from pressure and stretching. Diet, drugs and habit are all fully dealt with in every textbook. But let us learn to appreciate the daily high enema and to value it as it deserves. We need not fear that we are washing away many valuable "heat units" of as yet unabsorbed food. Practically all

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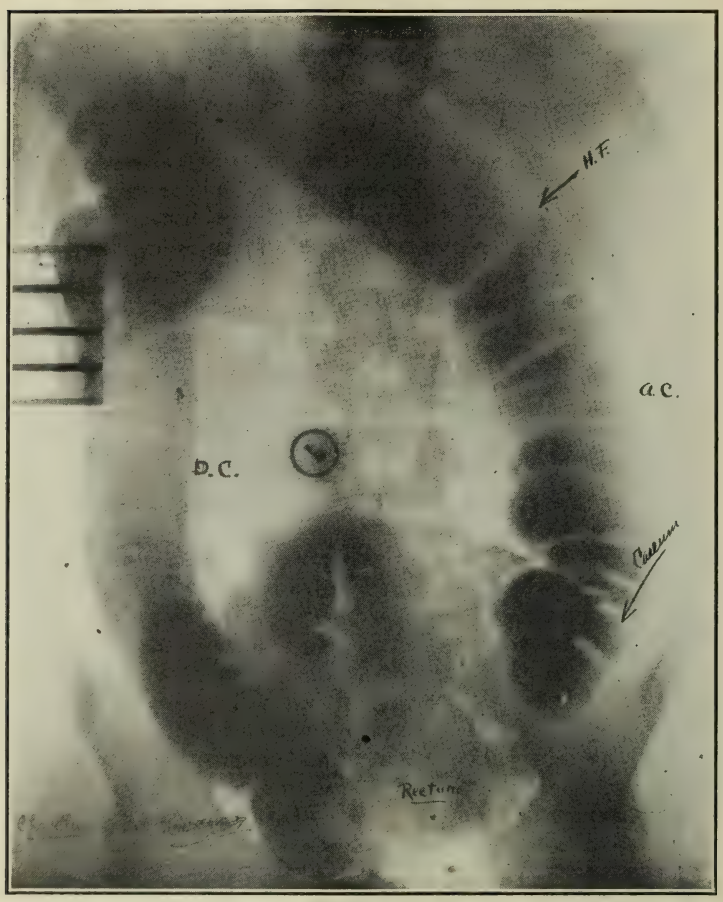
[5]Such a closure of the pylorus with the checking of the exit of the gastric contents was demonstrated experimentally by Tobler. Tobler. Ztschr. f. physiol Chem., 1905, Vol. XLV, p. 195.

[6]Hertz: Constipation and Allied Diseases. 1911.




*Case No. 26. W. B.* A case showing "the delay" principally at the splenic flexure; Bismuth injection; Bowels moved with *aid of cathartics* only every *second or third week.* Note also position of sigmoid and rectum, and lacking hepatic flexure angle, and distortion at splenic flexure. Patient enjoyed fair health, but complained of "being somewhat constipated." Daily high enemas, and agar-agar much improved patient after two months' treatment. He was then able to defecate three times a week without aid. Later old condition returned. Operation refused. In this case there was good progress up to the colon. *With entire tract empty* sounds were heard at ilio-colic region in five to six hours.

of the real energy and tissue-building elements have been absorbed long before.

We are fostering the return of blood to the part and are allowing it to rest up, as it were, and to regain its tone. Later it may be taught to do its work unaided. Surely daily enemas, over a long period very often, will do more to right matters than an occasional Johnstown flood let loose from above by either salines or cathartics.

343 Dolphin street.

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UNCOMPLICATED PREGNANCY AND LABOR. Presenting a Simple Scientific Method of Treatment of the Disorders of the Pregnant Term, for Their Cure, and for the Prevention of the Complications of Labor, to Induce a Normal Balance of All Functions, so that a Labor Without Pain in a Very Large Part is the Result. By Finley Ellingwood, M. D., Chicago, Illinois, Author of Ellingwood's Materia Medica and Pharmacognosy, Ellingwood's Practice of Medicine, a Synopsis of Medical Chemistry, Manual of Urinalysis and Editor of Ellingwood's Therapeutist. Chicago: Ellingwood's Therapeutist, 32 N. State street. 1913. Cloth.

The purport of the above volume is that the complications and pain incident to labor are unnecessary evils contrary to the usually accepted notions of both the laity and profession. Doubtless the profession from long preconceived ideas and experience come to look upon certain phases of labor as part of its penalty and that those who escape are indeed fortunate. Ellingwood is of the opinion that many of these so-called accompaniments of the pregnant state as well as labor are absolutely unnecessary, and in the volume above mentioned has laid down rules and regulations which he states will to a large extent avoid these disagreeable features. He lays the blame for the apathy of the profession in this respect upon the difficulty in educating the patient to a realization that the pregnant state is a dangerous crisis in her well-being, that she is stepping upon dangerous grounds, that by a careful regulation of her daily life the ordinary dangers may to a large extent be avoided. He goes very thoroughly into the causes which result in the disorders of pregnancy and the methods of escaping them, likewise the proper hygienic management of the pregnant woman. The book, though small, is of a high degree of excellence and should at some future date be elaborated upon. Ellingwood has done a good service to womankind in general by calling attention to the woeful lack of resourcefulness of most of the profession when caring for those carrying child.

# ETIOLOGY OF PHLYCTENULAR CONJUNCTIVITIS.

*By E. A. Knorr, M.D.,*
Surgeon to Presbyterian Eye and Ear Hospital.
*and*
*H. J. Maldeis, M.D.,*
Pathologist to the University Hospital and Presbyterian Hospital.

PHLYCTENULAR conjunctivitis is not only one of the oldest and most frequent diseases of the eye, but, among children, the most frequent, and has, in turn, excited the interest of the ophthalmologist, pediatrist and research worker.

The cause of the disease has not been definitely proven, and if we accept the prevailing idea that it depends upon an ectogenous and endogenous factor, it has not been shown to what extent either factor is involved.

The original conception of the disease as expressed by Chandler[1] in 1780 was that the phlycten was a vesicle caused by such ectogenous factors that usually produce vesicles upon the skin, such as hot acrimonious fluids, sun's rays and bites of insects.

Beer[2] described the disease in 1813 under the title of ophthalmia externa scrofulosa, and goes into detail in his description of the scrofulous child. This idea of Beer that phlyctenular conjunctivitis was dependent upon a general underlying endogenous factor was not only shared in by ophthalmologists of his time, including Heiling,[3] Little[4] and Lawrence,[5] but existed up to 1875, and we find the disease described under the same title by Seitz and Zehender,[6] Wells[7] and Reindorf,[8] and work done in recent years tends to strengthen this idea, although since the discovery of the tubercle bacillus in 1882 by Koch we cannot speak of scrofula as a distinct entity.

Among other views advanced concerning the etiology of phlyctenular conjunctivitis are:

Bacterial infection and its allied condition, eczema.

The exudative diathesis.

Indicanuria.

Under the influence of bacteriological investigation the view that phlyctenular conjunctivitis was due to a circumscribed ectogenous infection rapidly advanced, and numerous investigators, including Leber,[9] Bach[10] *et al.*, believed that they had discovered the exciting cause of the disease, viz., the staphylococcus pyogenes aureus, which was found in the conjunctival sac, and it was asserted by Bach that he had isolated it from the phlycten.

Burchardt in 1887 published his results in six cases of phlyctenular conjunctivitis; he isolated a coccus in two cases, inoculation of which into the conjunctival sac of dogs caused the development of phlyctens.

Straub examined six cases of phlyctenular conjunctivitis associated with eczema of the skin, and found the staphylococcus in all lesions.

Bach also produced the disease in dogs by inoculating the conjunctival sac with the staphylococcus pyogenes aureus, and be-

lieved that the phlycten and the eczematous lesion from which he also isolated the staphylococcus to be the same lesion dependent upon the same organism.

Numerous other organisms have been found in the conjunctival sac by Heilburn[11] and many others, such as the xerosis bacillus, pneumococcus, diplobacillus, etc. These organisms are only occasionally present in cases of phlyctenular conjunctivitis.

McKee[12] reports six cases of phlyctenular conjunctivitis associated with the diplobacillus, but does not believe that it bears any etiological relationship to it.

Yakahaschi[13] claims to have isolated the streptococcus from the normal conjunctival sac in 30 per cent. of cases examined. He used a culture media containing horse serum.

We rarely see phlyctens develop in the ordinary forms of conjunctivitis due to Kock-Weeks bacillus, gonococcus, pneumococcus, diplobacillus, etc., but usually find the disease associated with eczema, impetigo contagiosa, pediculosa capitus and a generally unhygienic condition of the patient.

Pick[14] inoculated the conjunctival sac of a dog with the contents of an impetigo vesicle, and in three days there developed a conjunctivitis with an eruption of phlyctens. He developed a pustule upon his own forearm by inoculation with the conjunctival secretion.

Von Michel[15] considers the phlycten a lesion of eczema, and bases his opinion upon the analogy of the histology of the phlycten and the eczematous lesion of the skin.

That the toxins of various organisms alone are not capable of producing phlyctenular conjunctivitis, at least as far as rabbits are concerned, has been abundantly shown by Dr. Randolph.[16]

1. Stephanson[17] found among 669 cases of phlycenular conjunctivitis 53 per cent. affected with eczema.

2. *Indicanuria.* Indican is formed from indol, and is a product of proteolytic cleavage. Mackee[18] recognizes three forms of indicanuria: 1, intestinal; 2, suppurative; 3, metabolic.

One is often puzzled to interpret the significance of indicanuria, for he has no sooner begun to attach importance to the presence of a strong indican reaction in certain cases, his faith in this as a sign of disease is shaken by the fact that he finds a strong indican reaction in the urine of some person who is apparently well.

Columbo[19] reports that he had found indican in the urine in 42 out of 43 cases of phlyctenular conjunctivitis. This article was followed by another last year, when he reported 115 cases of phlyctenular conjunctivitis and keratitis, 82 per cent. of which showed either indican or urorosein in the urine.

This question has been looked into by von Hippel[20] and Stuelp.[21] Von Hippel examined the urine of 416 patients suffering from all forms of eye disease, and only found 16 to show indican in the urine. Among this number 61 had phlyctenular disease, two of whom had indican in the urine.

Columbo noted the discrepancy between his results and those of von Hippel, and suggests that the 61 cases must have been something else.

Stuelp tabulates 511 cases, including all forms of eye disease except phlyctenular conjunctivitis. Eight per cent. showed indicanuria, and among this number many had definite causes for their eye disease, in addition to indicanuria.

Stuelp concludes that we cannot attribute to indicanuria an eye disease until we have excluded all other causes.

3. *The Exudative Diathesis of Czerny.*[22] — The exudative diathesis of Czerny is a congenital defect of metabolism excited by overfeeding of fat, and manifests itself during the first year of life. The symptoms of this disease, besides phlyctenular conjunctivitis, are seborrhea, milk crust, lingua geographica, catarrh of the nose and throat.

This condition as a factor in the etiology of phlyctenular conjunctivitis has found some support in Schutz and Videky,[23] who seek to occupy a compromise position, attributing some cases to the exudative diathesis and the rest to tuberculosis. Thus in 61 cases of eye disease, including 49 cases of phlyctenular conjunctivitis, they obtained a positive von Pirquet in 72.7 per cent., negative in 27.3 per cent.

Schutz and Videky[24] further report their experience with 102 cases of phlyctenular conjunctivitis, and again divide them into two classes. Those caused by the exudative diathesis, provoked by a diet rich in fats and sugars, which do not react to the tuberculin test, but get well on an exudative diet; that is, a vegetable diet.

The second class react to tuberculin injection, and includes the greater portion. This condition, described by Czerny, has found but little support except that of Schutz and Videky.[25]

Many research workers have applied themselves to this problem, and the trend of their effort has been to demonstrate the tubercular nature of the disease, as the phlycten anatomically bears a resemblance to the tubercle; in that it is a solid node, the center of which is composed of epithelioid cells surrounded by a wall of round cells, occasionally containing giant cells of the Langerhans type; it undergoes necrosis and ulceration. It differs from the tubercle in that it is vascular and tends to disappear, while the tubercle is avascular and tends toward chronicity; further, the phlycten is sterile.

New light was shed on this problem by the use of tuberculin as a diagnostic reagent subcutaneously and upon the skin.

Von Pirquet[26] has demonstrated the value of the tuberculin skin reaction. The following are the results obtained by several investigators in children having phlyctenular conjunctivitis, employing the von Pirquet test:

Weekers: 142 cases; 91 per cent. positive.[27]

Bednarski: 100 cases; all positive. Rosenhauch, using Moro's

salve: 50 cases; 96 per cent. positive; 50 cases healthy children, 4 per cent. positive.

Many investigators have also noted that children react toward the tuberculin test by an eruption of phlyctens.

Schutz-Zehden,[28] two cases. Siegrist,[29] four cases, following the ophthalmo-tuberculin test. Moro and Doganoff,[30] four cases. Tobias[31] reports infiltration in the cornea after subcutaneous injection. It was believed by some that tuberculin contained disintegrated tubercle bacilli, but Zieler,[32] by painstaking effort, has shown that tuberculin is free from such remains.

That the phlycten is sterile has been shown by Müller,[33] who examined 25 phlyctens and failed to find tubercle bacilli. The same result was obtained by examining the scrapings of phlyctenular ulcers of the cornea.

Müller removed 20 fresh phlyctens from children having enlarged cervical glands, and implanted them into the anterior chamber of dogs. In 18 the phlycten was slowly absorbed without suppuration or tuberclous formation. One developed panophthalmitis, and one tubercle nodes in the iris. Many experimenters have tried, and with some success, to produce the disease experimentally upon dogs and guinea pigs.

Leber[34] injected sterile tubercle bacilli into the cornea, and succeeded in producing a keratitis which bore some resemblance to phlyctenular keratitis. His experiments of injecting tubercle bacilli in the blood failed to cause the development of phlyctens.

Bruns[35] injected sterile tubercle bacilli into the carotid artery of dogs, and also the same mixed with flour and graphite, and obtained the following results:

| Material injected. | Death without changes. | Eye lost by necrosis. | Phlycten conj. | Foci in iris and choroid. | No change. | Number of cases. |
|---|---|---|---|---|---|---|
| T. B. + flour.... | 2 | 5 | 2 | 2 | 1 | 12 |
| T. B. + graphite. | 0 | 2 | 2 | 1 | 0 | 5 |
| T. B. alone..... | 5 | 3 | 1 | 2 | 5 | 16 |
| Total..... | 7 | 10 | 5 | 5 | 6 | 33 |

The five cases of phlyctenular conjunctivitis resembled the same disease in children, clinically and anatomically. The eyes lost by necrosis resulted from embolism of the ciliary arteries by the flour and graphite.

Rosenhauch[36] produced phlyctens experimentally upon dogs and pigs by injecting them with tubercle bacilli and inoculating the conjunctival sac with staphylococcus pyogenes aureus. The same experiment, using tuberculin instead of bacilli, gave the same result.

Rosenhauch also succeeded in producing phlyctens by the use of staphylococcus toxin and vaccine. In 22 control animals in whose

conjunctival sac were placed staphylococcus aureus, diplobacilli and colon bacilli but two developed phlyctens—diplobacilli cases.

Rupert's[37] experiments were as follows: Ten dogs and 13 guinea pigs were injected with tubercle bacilli of the human and bovine type subcutaneously, intraperitoneal and intrapleural. Twenty-three days later tuberculin was instilled in the right conjunctival sac four times a day for three days. Result: Three dogs and two pigs developed phlyctens; two dogs and two pigs died during experimentation and several later after the development of phlyctens.

Staphylococcus vaccine was tried on four dogs and five pigs. Result: One pig developed phlyctens.

Massage on three dogs and four pigs. Result: No phlyctens.

Chrysarobin on five dogs and four pigs. Result: No phlyctens.

Staphylococcus toxin on six dogs and eight pigs. Result: One dog and one pig developed phlyctens.

Eight dogs and six pigs injected with tuberculin, and tuberculin instilled frequently in the conjunctival sac for two days. Result: No phlyctens.

Staphylococcus toxin also failed to cause the development of phlyctens. This experiment was repeated three weeks later with the same result.

Staphylococcus toxin and tuberculin was instilled into the conjunctival sac of healthy animals, animals rendered weak by starvation and others rendered anemic by bleeding. Result: No phlyctens.

Dr. H. J. Maldeis and myself repeated the experiments of Rubert, using a lesser number of animals and substituting rabbits for dogs, but were unable to cause the development of phlyctens. Perhaps rabbits are not susceptible to the disease.

The experiments of Rosenhauch and Rubert show that phlyctens can be produced experimentally which, clinically and anatomically, resemble phlyctens of human beings; that these phlyctens develop only in animals injected with tubercle bacilli or tuberculin; that the external irritant is not a specific nor bacterial one, having been produced by tuberculin and staphylococcus toxin. Against the bacterial origin of the disease is the work of Müller, who showed the phlycten to be sterile.

Traumatism is not a factor in the development of the disease, but it has not been demonstrated that other factors, such as chemical irritation, strong light or disease of the nose, are not factors in the production of the disease in individuals having a tubercular infection.

Concerning the question whether phlyctenular conjunctivitis is always a sign of tuberculosis, it can be answered by the statistics of Axenfeld, Weekers, Bednarski, Beer and others, who found from 88 to 100 per cent. of their cases reacting to the von Pirquet test.

Why this disease, depending upon a general infection and a local

irritant that comes in contact with the entire conjunctivitis, is a focal eruption, can be answered by analogy with acute infectious diseases, as measles, chicken-pox and syphilis, that manifest themselves by focal skin eruptions.

There can be but little doubt that the recurrent phlyctenular disease of children depends upon a tubercular infection.

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# CORNEAL ULCERATION.

*By C. J. Stallworth, M.D.*

ETIOLOGY, SYMPTOMATOLOGY AND TREATMENT.

First—I shall consider concisely the anatomical and physiological characteristics of the cornea.

This transparent structure is situated in the anterior aspect of the eyeball, being placed as if a watch crystal, upon the sclera. Entering into its makeup there are five layers. First, or epithelial layer, which is simply a continuation of the epithelium of the conjunctiva. This layer is loosely adherent to its underlying structure, therefore the ease with which a corneal abrasion is produced.

Second Layer—This is known as Bowman's membrane, or the anterior fibrous layer.

Third—This is the middle layer, or otherwise known as the substantia propia. This portion of the cornea is composed of fibrillae of connecting tissue, the interlacing of which go to make up the numerous lymph spaces, the nutrition of the cornea finding its way to this structure by way of these spaces.

Fourth—This layer is known as Descemet's membrane. It is a thin, a very resistant layer, sometimes remaining after a most severe ulceration of the cornea.

Fifth—This is the endothelial layer, and represents a portion of the lining of the anterior chamber. The cornea at its margin abuts with three membranes—the conjunctiva, sclera and uveal tract. There are no blood vessels. The nutrition is derived from the anterior ciliary vessels.

*Nerves*—The nerve supply is derived from the ciliary nerve, which gives off numerous branches; hence the sensitiveness of the cornea.

The function of the cornea, of course, is that of causing a convergence of rays of light which afterwards pass through the lens and are focused on the retina.

Corneal ulceration and inflammation, more commonly known as keratitis, is one of the most frequently observed eye conditions, and especially so in our free dispensaries, this fact being due largely to the class of patients with which we have to deal, poor hygiene and gross uncleanliness lowering the vitality not only of the patient, but indirectly that of the cornea. I find that during the year 1912 there were 6000 eye cases treated at the Presbyterian Eye, Ear and Throat Hospital, and that over 5½ per cent. of this number were corneal ulcers. The greater number of these were found in adults. The cornea is said to be less resistant to disease and trauma as age progresses.

During the course of an inflammation of the cornea we observe

three stages—first, that of infiltration, during which stage leucocytes migrate in hoards to the diseased area, gaining entrance both through the lamellae of the cornea and from the conjunctival sac, provided there be a primary ulcer. As a consequence of this deposition of cells the cornea loses its transparency, taking on a smoked-glass appearance. The subsequent fate of the infiltrate varies; either resorption or suppuration, resorption only taking place when there is not an excessive amount of this infiltrate. Suppuration, however, is the one with which we are most concerned. If the amount of exudate becomes incompatible with the maintaining and absorptive powers of the cornea, then we have a localized breaking down and ulceration of the latter structure, the process of disintegration beginning in the most anterior layer, this localized loss of substance being recognized as a depression, the diagnosis of which may easily be made either by oblique illumination or with fluorescein. This ulceration, bounded by floor and wall of infiltrated tissue, is now said to be in its progressive stage; later the boundaries of this area incapable of living are cast off. After this procedure the base and edges of the ulcer acquire a smooth and glistening luster. It is said now to be in its regressive stage. Almost invariably after a more or less severe ulceration there appears an opacity in the substance of the cornea. This histological process has been for many years the subject of most careful and zealous investigation, the leading authorities not being able to agree as to the origin of the cells or tissue which enters into the make-up of the opacity. Some maintain that the new tissue is due to an organization of leucocytes which remain following the ulcerative process, Cohnheim being the foremost advocator of this theory. Stricker and others think, however, that it is due merely to a proliferation and increase in density of the normal fixed cells of the cornea. I believe that both play a part in the opacity formation. Of course, the above is only noted after a destruction of the corneal stroma. When there is a destruction of the epithelial layer only, the opacity is short-lived.

The etiology, symptomatology and treatment will be considered in connection with each class of ulcers.

*The Simple Ulcer*—This ulcer occurs either at the corneo-scleral margin or upon the cornea itself, and is usually the result of some slight trauma or the breaking down of a phlyctenule. They are scarcely larger than a millet seed, and never become purulent. This form of ulcer is quite frequently noticed in infants, being due to alterations in nutrition, dentition and sometimes seen during the course of the mild eruptive fevers. In older children it is usually found in those who have developed strumous tendencies.

*Symptoms*—Pain, photophobia and lacrymation are among the most prominent, pericorneal injection sometimes being present.

*Treatment*—Locally, mydriatics are used to put the eye at rest, this not being necessary, however, in the less severe cases. Bichloride solution, 1-5000, every three hours is usually the only treatment necessary. In more pronounced cases, and especially those due to the breaking down of phlyctenules, a 2 per cent. salve of yellow oxide of mercury is very efficacious. Some advocate the subconjunctival injection of normal saline solution.

The cases of phlyctenular ulceration should always be treated constitutionally, frequently responding quickly to the administration of iodides in small doses.

*Oicus Serpens,* or more commonly known as serpigenous ulcer, is so designated from the insidious and creeping manner in which it spreads, and not, as many think, from its likeness to a serpent. This form of ulcer first appears as a yellowish-white disk, and presents itself most usually near the center of the cornea. The opacity of the disk, unlike the other form of ulcer, is greater around its edges. The surface of the cornea over the disk first appears as if somewhat elevated, but soon this opacity is seen to be depressed in the form of a shallow dimpling. The rest of the cornea almost invariably presents a steamed appearance. Concomitant conditions of this ulcer are severe iritis and quite marked hypopyon.

*Etiology*—An ulcus serpens originates in the infection of the cornea by virulent organisms, the pneumococcus being the one most frequently found. An almost unnoticeable injury to the cornea sometimes affords a portal of entry to these organisms.

Traumatic ulcus serpens attacks adults almost exclusively, and especially those belonging to the laboring class, not only because their occupations predispose them, but on account of the neglected state of their conjunctivae and lachrymal sacs. Stonemasons and farmers are especially predisposed to this condition. This recalls a case treated in the Presbyterian Hospital last October.

A man who had received a very slight injury to the cornea while harvesting wheat, later developed a most violent keratoiritis, which very nearly necessitated enucleation. This condition also occurs in the acute infectious fevers, being most frequently observed in variola.

*Symptoms*—This ulcer shows a marked tendency to spread; signs of violent inflammation are noted soon after the infection; the lids are swollen, marked circum-corneal injection, photophobia is quite pronounced, and so is the pain, which radiates toward the supra-orbital and temporal regions. Tenderness of the eyeball is also a frequent symptom.

### NON-SUPPURATING ULCERS.

Dendritic ulcer is so named on account of its peculiar shape, not unlike the branches of a twig. It is slow in progress, running an

insiduous course and rarely attended by the inflammatory reaction noted in other forms.

*Etiology*—The micro-organism which is supposed to cause this condition has not been isolated. It occurs most frequently in young people of low vitality, and older individuals with irregular habits and depleted constitutions.

*Symptoms*—They are similar to other forms, but less severe.

*Treatment*—Locally a few drops of zinc chloride solution, one-half of 1 per cent. instilled three times a day, or a 4 per cent. formalin solution used at similar intervals. Scopolamine hydrobromate solution twice daily should also be used for mydriasis. The pain in this variety of ulcers is sometimes almost unbearable, requiring a hypodermic injection of morphia. Internal medication is also efficacious in this condition, strong mineral tonics being administered with excellent results.

### MALARIAL TYPE OF ULCER.

This variety of ulcer occasionally occurs in persons who are or were sufferers with malaria. The ulcer has no characteristic shape, sometimes resembling very closely the dendritic type. The patient gives a history of malarial attacks, and the presence of malarial organisms in the blood confirms the diagnosis.

The symptoms are similar to those of dendritic ulcer with the exception of less severe pain.

*Treatment*—The administration of quinine and arsenic will cause it to disappear. Locally, a prescription containing—

℞ Hydrastine hydrochlorid, gr. ss.
Aquae rosae, ℥i.
Aquae laurocerasi, ℥ii.
Aquae dist., ℥ii.
Sig.—Bathe eye three times daily.

Ulcers are sometimes noticed during the course of gonorrheal ophthalmia and ophthalmia neonatorum, the prognosis of which is considered very grave when this complication is present. A loss of vision almost invariably follows.

Trachoma likewise is frequently complicated by ulceration of the cornea, the latter being followed by the condition known as pannus.

Herpes of the cornea frequently break down and form ulcers.

Vision is markedly impaired as a result of corneal ulceration, especially after the severe attacks, the opacity serving as an obstruction to the rays of light, and quite frequently a great deal of astigmatism is brought on.

# Book Reviews.

PSYCHANALYSIS: ITS THEORIES AND PRACTICAL APPLICATION. By A. A. Brill, Ph.B., M. D., Chief of the Neurological Department of the Bronx Hospital and Dispensary; Chief Assistant in Psychiatry and Neurology at Columbia University Medical School; Formerly Assistant Physician to Central Islip State Hospital and to the Clinic of Psychiatry, Zurich. Octavo of 337 pages. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Company. 1913. Cloth, $3.00 net.

Gradually the medical profession, both here and abroad, have come to realize that there is a large group of diseases, the so-called border line cases in mental diseases, the psychoneuroses, the understanding and treatment of which has been sadly neglected. The work and enthusiasm of a few pathfinders, however, have made known these deficiencies to an extent at least. By precept, example and constant writing, these observers have gradually awakened in the medical profession a sense of their shortcomings as regards these diseases until at last the wave of psychotherapy which has swept the Continent has made itself felt in this country. Abroad its adherents claim brilliant results, and one needs only review the works of the several schools to be convinced that psychotherapy is no empty term, but an actual branch of medicine, and in the psychoneuroses that it is the only effectual agent.

There are many schools concerning the nature of the psychoses and neuroses. The present volume deals mainly with that of Freud. Unlike other schools, this discards all generalities and confines itself to the individual. Freud as early as 1895 found that hysterical symptoms like neuralgia, paralyses, epileptiform attacks, etc., could be traced to actual psychic traumata which the patient could not consciously recall, but which could be readily demonstrated when the patient was put in the hypnotic state. In other words, the hysterical manifestations were not accidental, but had an actual cause. The connection between cause and effect was often quite obvious. The author cites the following example: "A very sick child falls asleep and the mother exerts all her will-power to make no noise to awaken it, but just because she resolves to do so she emits a clicking sound with her tongue (hysterical counterwill), which was repeated on another occasion when she wished to be absolutely quiet. This developed into a regular tic which lasted for years. In other instances the connection is not so simple, thus psychic

pain may cause a neuralgia, etc." Freud concluded that these psychic traumata, or the memory of the same, act like foreign bodies in consciousness, and even long after their occurrence continue to influence like causative factors.

According to the writer this fixation of the psychic life on the pathogenic traumas is one of the most important, and, from a practical viewpoint, one of the most significant characters of the neurosis. The treatment consists with the patient under hypnosis, of reconducting the excitement from its false paths to the original conscious idea and then by working it off by means of intellectual labor and speech. Freud found one drawback to this treatment, namely, all patients are not hypnotizable. This led Freud to avoid hypnotism, and to adopt a procedure which he called the psycho-analytic method. He found that the urging and assuring patients that they did not remember the first motive of the symptom in question, that they would finally recall the pathogenic ideas without hypnotism.

The book enters into a thorough analysis of the psychoneuroses, dreams, the actual neuroses, obsessions, doubts, phobias, psychological mechanisms of paranoia, etc., etc. It is a philosophical work, not only well but entertainingly written. The author certainly writes with conviction and those who read will unconsciously come around to his beliefs, as the theories which are expostulated are reasonable and tenable. The book is something out of the ordinary, and should open up new avenues of investigation in the subjects treated, as well as hope of relief to those unfortunately affected with a neurosis of one form or another. Every neurologist should make a careful study of its contents, and general practitioners will be materially benefitted by familiarizing themselves with its precepts.

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The Surgical Clinics of John B. Murphy, M.D., at Mercy Hospital, Chicago. February, 1913. Volume 11, No. 1. Philadelphia and London: W. B. Saunders Company. Published bi-monthly. Paper, $8 per year.

As in the former issues of this publication, so with the present a great deal of space is devoted to bone surgery, in which line of work Dr. Murphy stands at the head of the American profession. The open treatment of fractures, osteitis of femur, luxation of semilunar cartilage, floating cartilage, arthrodesis, decompression, fracture and luxation of the neck of the humerus, laminectomy, etc., are thoroughly treated from the surgical standpoint. Dr. Murphy's results in bone surgery are so unique and epoch-making that the general surgical profession is indeed fortunate to be able to procure his experience at first hand and in such condensed form. The up-to-date member of the profession can ill-afford to be without the clinics as a regular bi-monthly visitor.

# MARYLAND MEDICAL JOURNAL

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BALTIMORE, APRIL, 1913


## ALIMENTARY INTOXICATION.

DURING the past few years alimentary intoxication has been recognized as the causative agent in many of the obscure ills of mankind. The term, however, is obscure, as it includes poisonings of many varieties and kinds and from any part of the digestive canal. As these poisonings, which include bacterial, food and drugs, are capable of setting up such a variety of ills, it well behooves the medical profession to try to evolve order out of chaos. With this idea in view, W. Hale White of London, in the *British Medical Journal,* in an article on intestinal toxemia, says that the term itself shows our ignorance, for it is unscientific to group cases of poisoning according to the point of entrance of the poison. He emphasizes the importance of classifying alimentary poisoning according to the character of the poison rather than the portal of entrance, as it is a minor matter whether a murderer comes in through the window or a door. We subscribe heartily to his conclusions. Further, he iterates the term is too wide. An illness due to any poison absorbed anywhere from the mouth to the anus is strictly an alimentary toxemia, but the phrase should not cover a case of opium poisoning. Equally as confusing is the practice of speaking of the ills from the ingestion of infected food as food poisoning, not food toxemia. On the other hand, when the ingested food is not infected by pathogenic organisms, but makes the person who eats it ill, he is said to be suffering from intestinal toxemia; for example, a person who has urticaria after eating strawberries. The author, therefore, is of the opinion that the users of the term wish to convey the idea of a disease due to poisons made by micro-organisms resident in the alimentary tract, but with our present knowledge we can neither name the poison nor the offending micro-organism, and until such a time as we

can we will be working more or less in the dark. Much work has been done along the line of clearing up the obscurity of intestinal intoxication, especially in its treatment, such as the use of aperients in statis, as well as Lane's short-circuiting operation of the intestinal canal, but as yet no entirely satisfactory plan of procedure has been evolved.

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## THE TREATMENT OF PHTHISIS BY ARTIFICIAL PNEUMOTHORAX.

The treatment of pulmonary tuberculosis by artificial pneumothorax has of late been receiving marked attention by the medical profession. There are many who favor the procedure and just as many others who condemn the method. At any rate, the treatment is such a recent innovation that more time will have to pass before its place in our therapeusis can be definitely determined. Along these lines the work of Molon (*British Medical Journal*) will be of interest to our readers. In the *Gazz. degli Osped.* he gives his experience in this treatment in 45 cases. In 12 he was unable to induce pneumothorax owing to extensive pleural adhesions. In three the treatment had to be abandoned owing to the onset of complications. In six severe cases with bilateral lesions, afte a period of improvement, the lesion on the non-operated side increa ed so rapidly that the treatment had to be discontinued. In three m ked improvement followed, though, owing to adhesions, satisfactory pneumothorax could not be induced. In three the improvement was so marked that the patients left the hospital and refused further treatment. In 18, excellent results were obtained, and treatment is still being carried out. Four refused to continue treatment owing to the pain of the stretched adhesions. In the 33 in whom the treatment was thoroughly tested, 24 were improved. The author is thoroughly convinced that pleural adhesions offer the greatest difficulty to instituting this mode of treatment. He found the best regions for the injection of the gas to be the axillary and the infrascapular, and a right-sided pneumothorax better borne than a left. The amount of gas introduced varied from 100 c. c. to 1000 c. c., according to the tolerance of the subject. The best results were obtained in the unilateral cases, but treatment had to be carried out for over a year.

## Medical Items.

The General Alumni Association of the University of Maryland tendered a reception to Dr. Thomas Fell, the new Provost, at the Hotel Rennert, on the evening of Thursday, March 27, 1913.

Dr. John C. Hemmeter was the guest of honor at a large dinner given by Dr. William Gerry Morgan of Washington, D. C.

The long contemplated union of the Medical School of the University of Maryland and the Baltimore Medical College has been accomplished, and after the 1913 commencement all future graduates will receive the University diploma. Under the new plans Drs. A. C. Pole, Charles G. Hill, David Street, John D. Blake, Samuel K. Merrick, J. Frank Crouch, J. M. Rowland, Charles O'Donovan, G. Milton Linthicum, Ridgeley B. Warfield, Walter B. Perry and Tilghman B. Marden are now professors in the University of Maryland.

Dr. David A. Medders, formerly of Baltimore, was forced to flee from his home in Omaha, Nebraska, during the recent cyclone there. Dr. Howard V. Dutrow, a graduate of the University of Maryland, is supposed to be marooned in the Y. M. C. A. Building in Dayton, Ohio, and much anxiety is felt for his safety.

Dr. Page Edmunds is spending some time in Bermuda. Dr. Edmunds is recuperating from an infected arm, contracted from a patient, and is taking a rest on that account.

The engagement is announced of Miss Amelia G. Nixon of Baltimore and Dr. Colvin R. Reynolds of Clifton Forge, Va. The wedding will take place in June.

Dr. Thomas H. Buckler made a speech recently before the Labor Committee of the Delaware Senate in defense of the Ten-Hour Law now before that body.

Dr. Cecil Dabney, University of Virginia, class of 1910, has left for China to engage in missionary work under the direction of the Protestant Episcopal Church.

Dr. Mary Baer, superintendent of the hospital at Charila, India, is under treatment in Baltimore for an infected arm.

Dr. Clarence B. Farrar has resigned his position in the Sheppard and Pratt Hospital to accept a similar one in the New Jersey State Hospital, Trenton, N. J.

The regular health wardens by wards are as follows:

Ward 1—Dr. O. L. Long, 2701 Eastern avenue.

Ward 2—Dr. H. E. Laroque, 2040 East Pratt street.

Ward 3—Dr. August Palmisano, 316 South Exeter street.

Ward 4—Dr. H. K. Gorsuch, 117 West Saratoga street.

Ward 5—Dr. J. E. Heard, 202 Aisquith street.

Ward 6—Dr. J. T. Spicknall, 2112 East Baltimore street.

Ward 7—Dr. A. L. Rettaliata, 1038 North Broadway.

Ward 8—Dr. J. W. France, 1407 North Gay street.

Ward 9—Dr. C. T. Buckner, 1337 East North avenue.

Ward 10—Dr. B. Wess, 914 East Biddle street.

Ward 11—Dr. C. E. Downes, 1122 Madison avenue.

Ward 12—Dr. E. A. Munoz, 1801 Guilford avenue.

Ward 13—Dr. J. H. von Dreele, 846 West 36th street.

Ward 14—Dr. E. K. Ballard, 1622 Mount Royal avenue.

Ward 15—Dr. C. F. Jones, 1744 West North avenue.

Ward 16—Dr. G. A. Thiede, 1530 West Lanvale street.

Ward 17—Dr. G. W. Hemmeter, 800 Harlem avenue.

Ward 18—Dr. F. H. Vinup, 1221 Hollins street.

Ward 19—Dr. J. H. Ullrich, 22 North Carey street.

Ward 20—Dr. W. A. Knell, Augusta avenue and Frederick road.

Ward 21—Dr. A. E. Muse, 1000 West Cross street.

Ward 22—Dr. J. E. Poulton, 615 Columbia avenue.

Ward 23—Dr. C. P. Erkenbrack, 1412 Light street.

Ward 24—Dr. C. B. Wheltle, 1279 William street.

Dr. Charles W. Young, professor of bacteriology and pathology in the Union Medical

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PHILLIPS' REFINED CAMPHOR
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BALTIMORE

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College in Pekin, China, is a recent visitor to Baltimore.

Dr. George Walker has been appointed a member of the State-Wide Vice Commission.

Dr. William E. Wiegand is taking a trip through Florida and Cuba.

Twenty-four temporary health wardens have been named to assist in the general vaccination ordered for Baltimore city. They are as follows:

Dr. W. DeF. Olmstead, 1832 West North avenue.

Dr. John Wade, 118 South Broadway.

Dr. Joseph J. Valentini, 16 South Broadway.

Dr. Henry W. Weinberger, 724 West Fayette street.

Dr. M. Chideckel, 216 North High street.

Dr. J. Knox Insley, 2938 East Baltimore street.

Dr. John Girdwood, 102 East 20th street.

Dr. Frank J. Powers, 2511 East Preston street.

Dr. H. Young Westbrook, 237 Gorsuch avenue.

Dr. Frank J. Sebald, Aisquith and Eager streets.

Dr. Henry E. Gale, 260 West Hoffman street.

Dr. Benjamin McCleary, 404 North Payson street.

Dr. J. J. Morrissey, 3632 Roland avenue.

Dr. Charles P. Clautice, 548 Mosher street.

Dr. Henry C. Houck, Appleton street and North avenue.

Dr. H. F. Skillman, 1304 West Lafayette avenue.

Dr. Louis L. Lloyd, 641 West Franklin street.

Dr. R. A. Warner, 119 North Carey street.

Dr. J. C. Pound, 1302 West Lombard street.

Dr. M. A. O'Neill, 108 North Fulton avenue.

Dr. Thomas A. Stevens, 1229 West Cross street.

Dr. Frank O. Barrett, 19 North Carey street.

Dr. Otto M. Reinhardt, 1017 South Charles street.

Dr. J. L. Turlington, 102 East Fort avenue.

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### MARRIAGES.

Joseph Albert Chatard, M.D., Johns Hopkins Medical School, '03, to Miss Alice Marie Whelan, both of Baltimore, at Baltimore, March 26, 1913. This marriage is of special interest, as both father and grandfather of the groom have been well-known Maryland physicians.

Emil Novak, M.D., Baltimore Medical College, '04, of Baltimore, to Miss Elizabeth Grace Rogers of Jamaica Plains, Massachusetts, at Jamaica Plains, March 24, 1913.

Edward Eli Sollars, Maryland Medical College, '10, of Deer Park, Md., to Miss Mary Myrtle George of Oakland, at Mountain Lake Park, Md., March 4, 1913.

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### DEATHS.

John Shartle, M.D., of Welsh Run, Pa., died in Hagerstown, Md., March 12, 1913, aged 54 years.

Robert H. Campbell, University of Maryland, '89, died at his home in New Orleans, La., March 18, 1913. Dr. Campbell was formerly of Rockville, Md.

Israel W. Fulton, M.D., Washington University, Baltimore, '72, died at his home in Ardmore, Pa., February 14, 1913, from pneumonia, aged 66 years.

Ulysses P. White, M.D., College of Physicians and Surgeons, '94, died at his home in Artesia, N. M., February 3, 1913, from cerebral hemorrhage, aged 47 years.

Joseph T. Jarboe, M.D., College of Physicians and Surgeons, '89, died at his home in Hagerstown, Md., February 11, 1913, from nephritis, aged 58 years.

Charles S. Brower, M.D., College of Physicians and Surgeons, '80, of Phoenicia, N. Y., died in Kingson, N. Y., December 15, 1912.

Samuel Whitfield Hartt, M.D., College of Physicians and Surgeons, '89, died at his home in Seattle, Wash., February 5, 1913, from pneumonia, aged 47 years.

George H. Witter, M.D., College of Physicians and Surgeons, '85, died at his home in Wellsville, N. Y., February 13, 1913, aged 54 years.

James Daniel Cox, M.D., College of Physicians and Surgeons, '92, died at his home in New Salem, Pa., March 9, 1913, aged 51 years.

Price W. Atkins, M.D., College of Physicians and Surgeons, '78, died at his home in Marion, Va., March 2, 1913, aged 57 years.

Isaac Allen Fetherlof, M.D., College of Physicians and Surgeons, '77, died at his home in West Milton, Pa., February 16, 1913, aged 62 years.

James Everard Massey, M.D., University of Maryland, '71, died at his home in Rock Hill, S. C., January 20, 1913, aged 64 years.

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# ON THE REPORTING OF COMMUNICABLE DISEASES.[1]

*By C. W. G. Rohrer, M.D.,*
Maryland State Department of Health.

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## I. INTRODUCTORY.

"Surely it is better, by care and precaution, to preserve health while we have it, than first to lose it, and then pay the penalty in pain and affliction."

"O, Health! thou art above all gold and treasure: he that has thee has little more to wish for; but he that is so wretched as to want thee, wants every thing with thee."

I approach the above topic with considerable reluctance; indeed, I might almost say that I have taken up my pen with fear and trembling. My feelings at this moment are akin to those experienced by Moses of old when he removed the shoes from off his feet, realizing that he was standing on holy ground. It is not so much what I shall say, but the manner in which I shall attempt to say it, so as to gain my point without incurring the displeasure of a single one of the 800 physicians[2] practicing in the smaller cities, towns and rural districts of Maryland, which concerns me most.

Almost from the very beginning of recorded time mankind has taken a deep interest in communicable diseases, especially when these have prevailed in epidemic form. In verification of this statement we need but turn to the best of classics, the Holy Bible, and read of the grievous murrain of beasts and the plague of boils and blains[3] upon man and upon beast, both of which occurred nearly 15 centuries before the Christian era. Manetho mentions a great plague affecting the human race which occurred at a still earlier date; namely, in Egypt, in the reign of Semempses, about 2500 B. C.

For further proof of the antiquity of this subject, let the thoughtful reader turn to the pages of such remarkable landmarks in the progress of communicable diseases[4] as "A History of Epidemic Pestilences from the Earliest Ages: With Researches Into Their Nature, Causes, and Prophylaxis," by Edward Bascome, M.D., London, 1851; to Haviland's "Climate, Weather, and Disease," 1855; to Howe's "Epidemic Diseases," 1865, and to Parkin's "Epidemiology," 1880. Even the pages of Pliny's "Natural History," yellow with age, written in the first century, are well worth consulting; likewise Huxham's "Observations on the Air and Epidemic Diseases," 1759; Dr. Benjamin Rush's "An Account of the Bilious Remitting Yellow Fever as It Appeared in the City of Philadelphia in the Year 1793;" Mathew Carey's "A Short Account of the Malignant Fever Lately Prevalent in Philadelphia: With a Statement of the Proceedings That Took Place in Different Parts of the United States," November 30, 1793; Gallup's "Sketches of Epidemic Diseases in the State of Vermont; From Its First Settlement to the Year 1815. With a Consideration of Their Causes, Phenomena, and Treatment. To Which Is Added Remarks on Pulmonary Consumption," 1815, and Wickes' "History of Medicine in New Jersey, and of Its Medical Men, from the Settlement of the Province to A. D. 1800," 1879.

Among later and more readily available works of a similar character should be mentioned Hecker's "Epidemics of the Middle Ages," 1846; Keating's "History of the Yellow Fever Epidemic of 1878 in Memphis, Tenn.," 1879; Walford's "Statistical Chronology of Plagues and Pestilences as Affecting Human Life, with an Enquiry Into Their Causes," 1884, and Creighton's admirable two-volume work entitled, respectively, "A History of Epidemics in Britain From A. D. 664 to the Extinction of Plague," 1891, and "A History of Epidemics in Britain From the Extinction of Plague to the Present Time," 1894.

Both Hippocrates and Sydenham discourse eloquently on communicable diseases[5] occurring epidemically; Malthus, in his epoch-making work, which forms the bedrock of the science of vital statistics, entitled "An Essay on the Principle of Population; or, a View of Its Past and Present Effects on Human Happiness; With an Inquiry Into Our Prospects Respecting the Future Removal or Mitigation of the Evils Which It Occassions," 1803, devotes a chapter to the "Effects of Epidemicks on Tables of Mortality," while a fairly recent governmental publication from the facile pen of Dr. Joseph M. Toner, entitled "Contributions to the Annals of Medical Progress and Medical Education in the United States Before and During the War of Independence," 1874, is a mine of information of which every American physician can justly feel proud.

Dr. James Thacher's "American Medical Biography: or Memoirs of Eminent Physicians Who Have Flourished in America. To Which Is Prefixed a Succinct History of Medical Science in the United States from the First Settlement of the Country," 1828, the pioneer work on American medical biography, is replete

with interesting information pertaining to the earlier communicable diseases and their resultant epidemics. Reference would also be made to Webster on "Epidemics." A work of peculiar interest to the elder practitioners of this State is Dr. Thomas H. Buckler's "History of Epidemic Cholera, as It Appeared at the Baltimore City and County Almshouse, in the Summer of 1849. With Some Remarks on the Medical Topography and Diseases of This Region," 1851, declared by a contemporary author to be "the most eloquent sermon on sanitation extant."

Other standard works emphasizing the importance of a prompt reporting of all cases of communicable diseases, and the dire results of the neglect of his duty, could be mentioned, but it is not my present purpose to give a check list of the literature on the subject, and hence I shall pass on to my next subheading.[6]

## II. Why Report Cases of Communicable Disease?

There are numerous reasons why a physician should report his cases of communicable disease, and report them promptly. Some of these can be included under the caption of moral obligation, whilst others are mandatory and laid down by statute. If personal observation is worthy of credence, in my opinion it is very unusual for a physician to wilfully violate either his moral or his statutory obligation in this respect, but that such infractions of the law do occasionally occur the sequel will abundantly show.

---

REPORT OF A CASE OF INFECTIOUS DISEASE.

Disease .....Date .....19...
Name .....Sex .....Color .....
Age.....Years. Duration of Illness.....Weeks.
Address .....County
Signature of Reporter.....
Householder
Reported by.....
or Physician
Address of Reporter.....County

(OVER)

Figure I.—Notification card; usually denominated "infectious disease card." The State Board of Health expects every physician practicing in the State of Maryland, outside of the limits of Baltimore city, to have on hand a goodly supply of these cards. They are furnished *gratis* by the State Board.

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*First of all,* the reporting of a case of communicable disease is a moral duty which the physician owes to himself, to his family, and to the community in which he lives and plies his art. Truly, a physician, above all others, should be able to answer in the affirmative the question, "Am I my brother's keeper?" Unto him the people look for advice and counsel and guidance upon numerous topics other than those directly pertaining to health, and, it should be added, such appeals are seldom made in vain. His motives are believed to be, and rightly, largely humanitarian, and no one, professional man or layman, does more than he "for sweet charity's sake." He gives freely of his time, his talents, and

occasionally even of his means, which, owing to the fact that but few good physicians are really good financiers and collectors, are almost invariably slender, except in the case of a favored few.

It is not my intention to pronounce an encomium upon the character and liberality of the physician, but the following quotation, selected from the writings of the celebrated Dr. Benjamin Rush, is appropriate and interesting:

"Humanity has been a conspicuous virtue among physicians in all ages and countries. It manifests itself, "1st. In their sacrifices and sufferings, in order to acquire a knowledge of all the different branches of medicine. For this they spend months and years in dissecting dead bodies, or in the smoke of laboratories, or in visiting foreign, and sometimes uncivilized, countries, or in making painful and expensive experiments upon living animals. Many physicians have contracted diseases, and some have perished in these loathsome and dangerous enterprises, all of which are intended for the benefit of their fellow-creatures.[7]

"2nd. No sooner do they enter upon the duties of their profession than they are called upon to exhibit their humanity by sympathy with pain and distress in persons of all ranks. It is this heaven-born principle which produces such acts of self-denial of company, pleasure and sleep in physicians. It is this which enables them to sustain the extremes of heat and cold, and the most laborious exertions of body and mind. * * * This noble sympathy in physicians is sometimes so powerful as to predominate over the fear of death; hence we observe them to expose, and frequently to sacrifice, their lives in contending with mortal epidemics. The United States have lately furnished numerous instances of death in physicians from their ardent attachment to their patients. The graveyards of Philadelphia alone hold the precious relicts of three and twenty members of our profession who have died martyrs to this affectionate and heroic sympathy since the year 1793.[8]

"3rd. Humanity in physicians manifests itself in gratuitous services to the poor. The greatest part of the business of Dr. Sydenham seems to have been confined to poor people. * * * Dr. Boerhaave did a great deal of business among the poor. In his attendance upon them he discovered, it is said, more solicitude and punctuality than in his attendance upon his rich patients. Being asked by a friend his reason for so doing, he answered, 'I esteem the poor my *best* patients, for God is their paymaster.' Dr. Cullen spent the first years of his long and useful life in doing business for which he was never paid, and when he rose to the first rank in his profession, did not forget that humble class of people, from whom he derived his knowledge and reputation. Dr. Fothergill devoted an hour every morning, before he left his house, to prescribing for the poor, and in his annual visit to Leahall, in Cheshire, he spent one day of every week in the same humane and benevolent business. * * *

"4th. Humanity in physicians discovers itself in *pecuniary* contributions, as well as in advice, for the relief of the poor. I

have read an account of a physician in England who gave all the fees he received on a Sunday to charitable purposes. Dr. Heberden's liberality to the poor was so great that he was once told by a friend that he would exhaust his fortune. 'No,' said he; 'after all my charities I am afraid I shall die *shamefully* rich.' Dr. Fothergill once heard of the death of a citizen of London who had left his family in indigent circumstances. As soon as he was interred the doctor called upon his widow and informed her that he had some years before recovered thirty guineas for as many visits he had paid her husband in the days of his prosperity. 'I have since heard,' said the doctor, 'of his reverse of fortune. Take this purse. It contains all that I received from him. It will do thy family more good than it will do me.' A poor curate, who lived in the city of London upon fifty pounds a year, called upon this worthy man for advice for his wife and five children, who were ill of an epidemic disease then prevalent in that city. The doctor, without being requested, visited them the next day, and attended them daily until they were all cured. The curate, by great exertions, saved a trifling sum of money, which he offered to the doctor as a compensation for his services. He refused to receive it—but this was not all—he put ten guineas into his hand, and begged him, at the same time, to apply to him for relief in all his future difficulties. Similar anecdotes of his liberality might be multiplied without end. It is said he gave away one-half of all the income of his extensive and lucrative business, amounting, in the course of his life, to one hundred thousand pounds."

*In the second place*, a physician should report his cases of communicable disease,[9] because, by so doing, many serious and fatal epidemics may be averted. Then, too, the public health authorities will be enabled to meet the enemy face to face, instead of "bearding the lion in his den." They will have but a nursling to encounter compared with the huge giant which it may become.

The seeds of a noisome pestilence[10] are ofttimes unwittingly sown by the neglect of so simple a duty. "To be forewarned is to be forearmed," and in no field of scientific inquiry do we find such disastrous results convincing us of the truthfulness of the aphorism that "history repeats itself." Had this been borne in mind, mankind probably need not have been called upon to witness such an appalling spectacle as the terrible plague which spread over the world in A. D. 1345-49, leaving scarcely a fourth part of the human race alive. It spread throughout Asia, entered Egypt, Greece, Italy, Spain, England, and, lastly, Germany. The mortality was frightful. In the city of Florence, St. Anthony computed the number of victims to have been 100,000. (Villanius says about 60,000.) In London 50,000 deaths are said to have occurred in one week, 100,000 perished at Venice, 90,000 in Lubeck, and the deaths in the kingdom of Spain were computed at 200,000.[11]

Other instances illustrative of this principle might be cited with advantage, even here in our own State. But I shall refrain from so doing at the present time other than calling to mind the series

of 157 cases of typhoid fever which occurred in the Woodberry-Hampden district of Baltimore city in the summer of 1906. It was a milk epidemic, and had the first case of sickness been promptly reported this sentence need not have been written.[12]

*Thirdly,* besides being a physician's moral duty to report his cases of communicable disease, it also becomes his civil duty—his duty as a man and citizen—to do so. To him it is given to know that contagious disease exists in a community, and unto him the people naturally look for protection. He is identified with the progress and general uplift of all those who are fortunate enough to come within the range of his influence. This is essentially so in rural communities, where the faithful physician and the consecrated minister of the Gospel stand pre-eminent among their fellows.

It may be unseemly of me to say so, but I believe that we do not guard the status of the physician as faithfully as our forefathers did. Whilst I am not harking about the "good old times," yet I feel that the attention of the profession should be directed to this matter. A careful study of the history and rise of our cult in Maryland has prompted the above statement.

The distinguished Professor Gross, the elder, was the acknowledged champion who contended for the social rights of the physician a generation since. Hear what he said, among other things, on a certain occasion, on February 25, 1880:

"I have lived a good while in the world, and, having seen a great deal of society, I am safe in asserting that there is no profession, vocation or pursuit which, on this side of the Atlantic, enjoys a higher social status than the medical, the clerical not excepted. The refined and educated American physician is a prince among men, and his wife is ever his equal in the social circle. Indeed, she is often a leader in, and a queen of, society. * * *

"During my residence at Cincinnati and at Louisville I never failed, in attending an evening party, a dinner or a social entertainment of any kind, to meet with some of my professional friends and their wives, sons or daughters; and I speak advisedly when I declare, although it may be at the expense of repeating myself, that there is not a city or town of any considerable size in the Union in which the same state of things does not obtain. If you look at the medical profession in your own city you will find a further illustration of the truth of my statements. * * *

"The refined and cultivated society of Boston has always had a large share of the medical element. Its doors have always been open to the Warrens, the Haywards, the Channings, the Bigelows, the Jacksons, the Shattucks, the Bowditches, the Storers, the Reynoldses and others, as they still are to their descendants. Charleston, S. C., at one time contained the most brilliant and aristocratic society in this country. Nowhere has there been on this continent a higher type of civilization or a greater amount of elegant and refined breeding than in this once famous city—famous for its pretty and accomplished women and its noble, chiv-

alric and intelligent men. Its social entertainments were of the most *recherché* and costly character. * * *

"What is true of our larger cities in this respect is emphatically true of every town, village and hamlet of the Union. Go where we may, the refined and cultured physician is a man of mark, not a whit inferior in his social position to the clergyman, the lawyer, the scientist or the merchant prince. A great deal is said at the present day of the want of refinement and of the defective education of the medical student, as if he were the veriest boor in Christendom, hardly half-civilized, unwashed, unkempt and dressed in the shabbiest garb. We are all agreed that our systems of instruction are sadly out of joint; that they are not what they should be, or what, by-and-by, they must and will be; but I am quite sure that if you were some day to drop into my lecture-room while I am engaged in addressing nearly 600 students, assembled from all parts of the country, including representatives from different foreign lands, you would be surprised at their orderly conduct, their gentlemanly appearance and their intelligent countenances. Not only are many of these youths well educated, but they have been reared under the best influences, and are destined to make their mark in the profession as well as in the social circle. Our army and naval surgeons are, as everybody knows, admitted into the best society, both at home and abroad. Again, not a few of our young physicians marry into our most distinguished families, which would assuredlly not be the case if they were not well-bred, cultured and meritorious men. * * *

"Every man holds his social position in his own hand. If it be not his birthright, he can, if he choose, or is worth anything at all, gradually attain it, despite untoward circumstances. The requirement for admission into society in Philadelphia is said to be family, or blue blood; in New York, wealth, or money; and in Boston, literature, or mental culture. This may be so, but it is so only in a certain degree, and these landmarks are rapidly becoming merged into one another. Character alone should be the test of social distinction in a truly civilized country. * * *

"I cannot agree with you when you say that social position is not a thing for which men should struggle. I cannot see how this can interfere with a physician's usefulness. On the contrary, I regard it as one of the highest and most sacred duties of the medical man to cultivate the graces and amenities of social life. The absence of this quality lowers any profession in public estimation, and reduces it to the level of the ordinary pursuits of life. Let the medical man aspire to be a refined and cultured gentleman, and do all he can to adorn the higher walks of life, for just in proportion as he does this will he be respected by the community and add to the dignity of his profession."[13]

*Fourthly and lastly,* it is the legal duty of a physician to report his cases of contagious disease; in fact, this obligation is fixed by statute, and he has no choice in the matter. There is no middle ground. The reporting of a case of infectious disease[14] is so simple a thing, and the failure to perform this duty is involved with so

CHAPTER 436, ACTS OF 1898.

34 A. Whenever any householder knows that a person within his family or house is sick of smallpox, diphtheria, membranous croup, scarlet fever, typhoid fever, typhus fever, measles, mumps, whooping-cough, or any other infectious or contagious disease, dangerous to the public health, he shall immediately give notice thereof to the Board of Health of the city or county in which he dwells.

* * * Any person neglecting or refusing to comply with any of the provisions of this section shall be punished by a fine not exceeding one hundred dollars.

34 B. Whenever any physician knows that any person whom he is called to visit is infected with smallpox, diphtheria, membranous croup, scarlet fever, typhoid fever, typhus fever, yellow fever, measles, whooping-cough or any other contagious or infectious disease, dangerous to the public health, he shall immediately give notice thereof in writing, over his own signature, to the Board of Health of the city or town or county in which such disease exists; and if he refuses or neglects to give notice he shall be fined not less than fifty nor more than two hundred dollars.

(OVER)

Figure II.—Reverse side of an infectious disease card. It contains extracts from the Maryland law requiring a prompt reporting of all cases of infectious or contagious disease. It places the responsibility upon the physician, the parent and householder.

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much difficulty, if taken up and pushed by the proper authorities, that there is really no excuse for its non-performance. To be brought before the bar of justice for neglect of this duty becomes one of the painful incidents in a physician's life, the details of which he does not care to record in his diary or hand down the memory of them to his children and grandchildren. It is alike embarrassing to the public health officials and humiliating to the brother-physician incriminated, especially when one recounts his struggles as a student and the toils and hardships through which he must pass in order to obtain his degree. Then, too, the years of patient waiting and the charity work which he must do to establish a reputation should be considered.

The Maryland law on the subject of reporting communicable diseases[15] will next be given in detail. I wish to emphasize the fact that the physician is the responsible party when there is a physician in the case; otherwise, it is the parent or householder.

NOTIFICATION OF INFECTIOUS DISEASES.

*Chapter* 436, *Acts of* 1898..

34 A. Whenever any householder knows that a person within his family or house is sick of smallpox, diphtheria, membranous croup, scarlet fever, typhoid fever, typhus fever, measles, mumps, whooping-cough, or any other infectious or contagious disease, dangerous to public health, he shall immediately give notice thereof to the Board of Health of the city or county in which he dwells,

and upon the death, recovery or removal of such person or persons, such of the rooms of said house and such of the articles therein as, in the opinion of the local "Board of Health," have been subjected to infection or contagion, shall be disinfected by said Board of Health, and a written statement of the fact of such disinfection shall be given to such householder. Any person neglecting or refusing to comply with any of the above provisions shall be punished by a fine not exceeding one hundred dollars.

34 B. Whenever any physician knows that any person whom he is called to visit is infected with smallpox, diphtheria, membranous croup, scarlet fever, typhoid fever, typhus fever, yellow fever, measles, whooping-cough, or any other contagious or infectious disease, dangerous to public health, he shall immediately give notice thereof in writing, over his own signature, to the Board of Health of the city or town or county in which such disease exists; and if he refuses or neglects to give notice he shall be fined not less than fifty nor more than two hundred dollars.

34 C. The Boards of Health in the several cities, towns and counties shall cause a record to be kept of all reports received in pursuance of the preceding sections, and such record shall contain the names of all persons who are sick with infectious or contagious diseases, the localities in which they live, the disease with which they are affected, together with the date and names of the persons reporting any such cases, and the record of quarantine, isolation, disinfection and other preventive measures. The Boards of Health shall give the School Boards, of their respective counties, cities or towns, immediate information of all cases of infectious or contagious diseases reported to them according to the provisions of this Act.

34 D. When any Board of Health has had notice of the occurrence, within its sanitary jurisdiction, of a case of smallpox, or any other contagious or infectious disease dangerous to public health, such Board of Health shall, within twenty-four hours after the receipt of such notice, notify the State Board of Health of the same.

34 E. All questions of doubt concerning the cause or nature of any sickness believed or suspected to be of an infectious or contagious character shall be referred to the State Board of Health; and the said Board shall be authorized to employ a competent bacteriologist to conduct inquiries into the nature, source and vehicles of infectious disease. The services of the bacteriologist of the State Board of Health shall be free to all local Boards of Health, and to all practicing physicians in the State, for such inquiries concerning infectious and contagious diseases as the said Board may from time to time direct, and to the State Vaccine Agent for testing vaccine virus. The sum of twenty-five hundred dollars annually, or so much thereof as may be necessary, shall be paid by the Treasurer of the State upon the warrant of the Comptroller at such times and in such sums as may be authorized by the State Board of Health upon presentation of the proper vouchers for expenses.

34 F. Every person not a legally qualified physician practicing as midwife, or acting as attendant upon woman in child-bed in this State, who shall find any lying-in woman to have fever, shall forthwith notify the health officer of the district, and shall refrain from attendance upon any other parturient woman, or women in child-bed, until the local health officer shall give her written permission to resume such practice. Every midwife, obstetrical nurse or other person, not a legally qualified physician, attending for pay or hire, upon any lying-in woman, or woman in child-bed, shall send his or her name and address to be registered in the office of the Registrar of Vital Statistics for the city, town or county in which he or she resides. And any person violating the provisions of this Act shall be guilty of a misdemeanor, and shall, upon conviction, be fined not exceeding one hundred dollars or imprisonment not exceeding six months, or be both fined and imprisoned in the discretion of the Court.

The Maryland laws pertaining to the reporting of communicable diseases[16] are far-reaching in their scope. I shall next subjoin several sections enacted at an earlier date and entitled "Better Preservation of Public Health."

### Better Preservation of Public Health.

*Acts* 1890, *Chapter* 622.

1. Whenever any physician, or person acting as a physician, shall know or shall have cause to believe that any person whom he has attended during the last illness of such person in this State, outside the limits of the City of Baltimore, has died of smallpox, cholera, yellow fever, typhoid or typhus fever, diphtheria, leprosy, or any other disease of a contagious, infectious or epidemic character, the said physician, or person acting as a physician, shall, over his own signature, immediately give notice thereof to the Secretary of the State Board of Health, which notice shall state the cause of the death, the name, age, sex and color of the deceased, and such other information in connection with the existence and spread of the disease as may be deemed important for the protection of the public health; and if no physician has been in attedance during the last illness, or at the time of the death of such person, then it shall be the duty of the householder in whose house or upon whose premises the death occurred to transmit to the Secretary of the State Board of Health the facts in accordance with the requirements of this section.

2. Whenever any hotelkeeper, keeper of a boarding or lodging house, superintendent, manager or director of a private or public institution of any kind, shall know or be informed by a physician, or shall have reason to believe that any guest, inmate or other person in the hotel, boarding-house or institution over which he or she may have control or supervision, or on the premises thereof, is sick with or convalescing from smallpox, cholera, yellow fever, typhus or typhoid fever, scarlet fever, leprosy, or any other infectious or contagious disease,[17] the said owner, proprietor, manager or other person having charge, shall immediately give notice

thereof in writing to the Health Officer of the city or town in which the infected house or premises is located, or to the Secretary of the State Board of Health, if there is no local Health Officer who can efficiently deal with the case; said notice shall state the name and place of residence of the person sick, the name of the disease, the name of the owner, proprietor or manager of the house, and the locality of said house; and it shall be the duty of the local or State Health Officer, as the case may be, to take such steps and do such things as may be necessary to render effective the provisions of the Act of 1882, Chapter 155, "An Act to provide against the spread of infectious diseases."[18]

3. Any person or persons who shall neglect or refuse to comply with the provisions of the foregoing sections of this Act shall be deemed guilty of a misdemeanor, and shall, upon conviction thereof in a court of competent jurisdiction, be fined not more than fifty dollars for every such offense.

## III. Technique of Reporting.

The essential thing to do is to report the case. If this is done promptly and in good faith, no adverse criticism could possibly be offered by any fair-minded man. But if technicalities are to be observed, I might say that there is one right way and a number of wrong ways of performing this important duty. For example, if a case of communicable disease is reported on a slip of paper, instead of on the card designed for the purpose, it is hardly acceptable, although it undoubtedly would be an evidence of good faith on the part of the physician, the parent or the householder sending it in. However, the proper cards have been placed in the hands of every physician practicing in this State, and there can be no valid excuse for their not using them.

The face of the notification card for infectious diseases (*Vide* Figure I) contains spaces for a number of items. Every one of these should be filled out conscientiously and with each datum complete. Occasionally a physician will neglect to insert the name of the disease with which the patient is suffering; sometimes he omits the date, first name of the patient, sex, color, age, or duration of illness. He even has been known to overlook appending his signature.

On the reverse side of the infectious disease card (it is the card denominated "Report of a Case of Infectious Disease," and a copy of it appears as Fig. I) an extract from the Maryland law, Chapter 346, Acts of 1898, 34 A and 34 B, appears. This has also been reproduced, so as to bring it most conspicuously before the eyes of physicians and others, and appears as Fig. II. It sets forth explicitly the duty of the householder and of the physician in the reporting of communicable diseases. It also sets forth, in unmistakable terms and in plain English, the penalty attached for failure or neglect to comply with the provisions of this Act.

I have stated above that a case is not properly reported unless complete data are furnished. Again, a case is not properly re-

ported unless the report is made in writing. It must be down in "black and white." A verbal report, or a report by telephone, cannot be accepted as final, although such a step certainly expedites matters, and the report should subsequently be reduced to writing.

A case of infectious disease is not legally reported unless the report is transmitted to the local Board of Health; that is, to the town, county or district health officer. The law specifically states that notice shall be immediately given "to the Board of Health of the city or town or county in which such disease exists." Sending a report direct to the State Department of Health is an irregular way of reporting a case of communicable disease, and is not in strict compliance with the letter of the law. However, when this is done we accept same with thanks, make out a duplicate card and mail it to the town, county or district health officer, to whom the report should have originally been sent.

Sending a specimen to the laboratory for bacteriological examination is not reporting the case, be this sputum to be examined for tubercle bacilli, blood for a Widal test, or a swab from the throat of a diphtheria patient. An infectious disease card should be made out and transmitted to the health officer, just the same as if a specimen had not been sent to the laboratory for diagnosis; but a physician is justified in waiting for the result of the laboratory examination before sending in his report card. And right here I want to urge upon the physicians of the State a more general use of the bacteriological laboratory, both as an aid to diagnosis and also to determine with certainty the proper time to declare the throat of a diphtheria patient free from contagious germs. A terminal negative culture should be obtained from every diphtheritic patient before he or she is turned loose upon the public as cured. If this were required by law, so-called diphtheria "bacillus carriers" could not exist, and the monthly mortality and morbidity from this disease, instead of holding third or fourth place in the rank and file of infectious diseases, would be reduced fully one-half.[19]

Smallpox cases, being of unusual interest and importance, should be finally reported upon a special card improvised for the purpose. (A copy of a smallpox report card appears as Figure III.) It will be observed that entirely different data are required in cases of this highly contagious and loathsome disease. If physicians would make it a rule to vaccinate all persons within the circle of their practice every five years who cannot show a good scar, the dread smallpox would soon fail to find susceptible soil in Maryland. This would be much cheaper than the present antiquated method of starting a vaccination crusade after the disease has gained a foothold in the State, and incidentally spending thousands of dollars on quarantine and for feeding the smallpox patients, their families and other contacts.[20]

The proper thing for a physician to do when he is called to see a patient whom he finds suffering with what he believes to be smallpox is to report the facts *immediately* to the local health officer, preferably by telephone or telegram. It then becomes the

SMALLPOX.

Name .....Age .....
Town .....County .....
White or Colored.....Occupation.....
Date of attack.....190....
Where contracted.....Type of Disease.....
Died or recovered.....Date of Death or Discharge.....
Date of successful vaccination.....Is a good scar present?....
How many other persons in the same house?.....
How many were attacked?.....
Of these how many were vaccinated?.....
How many escaped?.....
Of these how many were vaccinated?.....
Signed by.....

On the back of this card, for the last patient in the house, please write the names of those who escaped attack.

Figure III.—Special Smallpox Card. When the Maryland law pertaining to vaccination is properly enforced, this card will become obsolete.

health officer's duty to proceed at once to make an investigation, accompanied by the attending physician. Should he, too, suspect smallpox, he should at once notify the State Department of Health to that effect either by telephone or telegram. The law requires that the State Board shall be notified promptly, certainly within 24 hours after a knowledge of the existence of such a suspected case.

The section of the Maryland law requiring the local health officer to promptly notify the Secretary of the State Board of Health concerning the existence of smallpox and other dangerous diseases[21] will next be given.

*Rev. Code*, 1888, *Art.* 43; 1886, *Chap. 22, Sec. 7.*

14. Whenever any local or county Health Officer shall receive reliable notice, or shall otherwise have reason to believe that there is within the limits of his sanitary jurisdiction a case of smallpox, or other disease dangerous to the public health, he shall immediately investigate the matter and take all proper steps for the restriction or suppression of such disease or diseases, and the said County Commissioners may incur and pay as other county expenses are paid the necessary and legitimate expenses thereof; he shall promptly notify the Secretary of the State Board of Health of the existence of any epidemic or unusual sickness or mortality that may come to his knowledge within his own sanitary jurisdiction or contiguous thereto, and when thus informed it shall be the duty of the Secretary of the State Board of Health to co-operate with and aid the local health authorities in making scientific and practical investigation into the cause or causes of any existing disease, and in devising the most efficient means for its restriction or suppression, or for the exclusion of any threatened disease,[22] and to this end he may exercise all the powers of the State Board of Health.

Tuberculosis is the only communicable disease in Maryland which is not reported through the local health officer. Cases of this disease should be reported on special cards prepared for the purpose. All the data should be faithfully supplied, especially an answer to the question, "Have tubercle bacilli been demonstrated in the sputum?" and the card enclosed in an envelope, sealed and mailed direct to the State Department of Health. This is imperative, as the information submitted concerning a tuberculous person is required by law to be regarded as sacredly confidential. Had such a feature not been agreed upon the tuberculosis bill, the first of its kind, never would have become a law. However, I sometimes think it would be well for health officers to be informed of the cases of tuberculosis existing within their respective jurisdictions. As it stands today, a health officer does not officially know of the existence of a tuberculous case in his territory until said victim is claimed by death or changes his habitation.

I shall next append the law requiring a prompt reporting of tuberculous cases.

### Registration of Tuberculosis.

*Chapter* 412, *Acts of* 1904.

Adding New Sections to Article 43 of the Code of Public General Laws.

Section 34 G. Be it enacted by the General Assembly of Maryland, that from and after the passage of this act the State Board of Health of Maryland shall keep a register of all persons in this State who are known to be affected with tuberculosis.[23] The State Board of Health shall have sole and exclusive control of said register, and shall not permit inspection thereof nor disclose any of its personal particulars except to officials authorized under the laws of Maryland to receive such information.

Section 34 H. The superintendent or other person in charge or control of any hospital, dispensary, school, reformatory or other institution deriving the whole or any part of its support from the public funds of the State of Maryland, or any city, town or county in the State of Maryland, having in charge or under care or custody any person or persons suffering with pulmonary or laryngeal tuberculosis, shall, within forty-eight hours after recognition of such disease, make, or cause to be made, in the manner and form prescribed by the State Board of Health, a record of the name, age, sex, color, occupation, social condition and residence of the person or persons so affected, together with such information as may seem necessary or important. And all such records shall be delivered under seal of the State Board of Health on Monday of the week immediately following that in which the records were made. Any superintendent or other person charged with a duty under this section who shall fail or refuse to comply with the requirements of this section shall be deemed guilty of a misdemeanor, and on conviction thereof shall be fined not more than twenty-five dollars.

SECTION 34 I. Whenever any physician knows that any person under his professional care is affected with pulmonary or laryngeal tuberculosis, he shall transmit to the Secretary of the State Board of Health within seven days, and upon blanks provided by the State Board of Health for that purpose, the name, age, sex, color, occupation, social condition and residence of such person, and any physician failing or refusing to comply with the requirements of this section shall be deemed guilty of a misdemeanor, and on conviction thereof shall be subject to a fine of ten dollars.

SECTION 34 J. The apartments occupied by any consumptive shall be deemed infected, and when vacated by death or removal of said consumptive occupant shall be disinfected by the Board of Health of the city, town or county in which such apartments are situated. And it shall be the duty of the householder, physician or other person having knowledge of the facts to notify the local Board of Health within forty-eight hours after the death or removal of a person affected with pulmonary or laryngeal tuberculosis. And any person failing to comply with the provisions of this section shall be deemed guilty of a misdemeanor, and on conviction thereof shall be subject to a fine of ten dollars.

SECTION 34 K. Any person who lets for hire or causes or permits anyone to occupy apartments previously occupied by a consumptive, before such apartments shall have been disinfected by a Board of Health, shall be guilty of a misdemeanor, and upon conviction thereof shall be fined twenty-five dollars.

SECTION 2. And be it enacted that this act shall take effect from the date of its passage.

*Approved April* 8, 1904.

So far, so good. Let us assume that the tuberculous case has been promptly reported by the faithful, law-abiding physician, on the proper card, with all the data complete, signed, sealed and mailed direct to the State Department of Health. Let us also assume that the physician, called in to see a patient in whom he suspects smallpox,[24] has telephoned the facts in the case to the local health officer; the latter has hastened to the scene, and, agreeing with the family physician in his provisional diagnosis, has telephoned or telegraphed the State Board to send a representative to verify it; the patient has been duly quarantined and all contacts vaccinated.

In reporting a case of one of the commoner types of communicable disease a slightly different program has been outlined. The name of the disease, the name of the patient, the date and all necessary information should be written on an infectious disease card, using a separate card for each case. (A copy of this card appears as Figure I.) This should be done immediately, as required by a special regulation adopted by the State Board of Health at its regular monthly meeting held on July 1, 1911, a copy of which is subjoined:

*The State Board of Health of Maryland at its regular monthly meeting, held July* 1, 1911, *passed the following order requiring*

C. D. No. 1.

STATE DEPARTMENT OF HEALTH OF MARYLAND.

DAILY REPORT SHEET

FOR LOCAL BOARDS OF HEALTH.

Board of Health of.....

Date of Report.....191

| Disease | Name | Color | Age in Years | Duration of Illness in Weeks | Address |
|---|---|---|---|---|---|
| | | | | | |
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Health Officer.

This Report Is to Be Mailed Daily in the Special Envelope Provided.

(OVER)

Figure IV.—Daily Report Sheet.
To be used by local Boards of Health.
Each health officer should have on hand a goodly supply of these daily report sheets, together with the return envelopes. Furnished *gratis* by the State Board of Health.

*the daily report of the following contagious and infectious diseases:*

"Ordered by the State Board of Health, that from and after this date all local boards of health in this State shall cause to be made daily reports of all cases of smallpox, typhoid fever, diphtheria, scarlet fever, measles, chicken-pox, whooping-cough, mumps, epidemic cerebro-spinal meningitis, acute epidemic anterior poliomyelitis, acute dysentery, influenza, Asiatic cholera and bubonic plague."

The physician has made out a card for his infectious disease[25] case, with all required data in full, and transmitted same to the local Board of Health, ordinarily addressing it to the health officer, who is secretary to the local Board of Health. If the physician has had more than one case of sickness, a separate card should be made out for each case. It then becomes the duty of that most maligned of all public servants, namely, the overworked and un-

derpaid health officer, to transcribe the complete data upon a daily report sheet and mail same to the State Department of Health."[6] The regulation does not require that each and every case shall be written upon a separate daily report sheet, but that all the cases received during a single day may be entered upon a daily report sheet at the close of the day and mailed to the State Department. If no case of infectious disease has occurred on any day, then no daily report sheet is expected. The health officer should be sure to date and sign the daily report sheet.

A copy of the daily report sheet appears in this article as Figure IV. Special envelopes, already stamped, are provided for the mailing of these sheets. Health officers are urgently requested to have on hand a generous supply of these envelopes and daily report sheets, which are supplied gratuitously by the State Department of Health.

A copy of the law requiring local Boards of Health to send in daily reports of infectious diseases appears on the reverse side of the daily report sheet. This has been photographed, and appears in this paper as Figure V. However, in addition to the photograph, the importance of this matter prompts me to subjoin herewith the paragraph from the Maryland law upon the subject:

ATTENTION OF HEALTH OFFICERS IS CALLED TO THE PROVISIONS OF SECTION 53 OF ARTICLE 43 OF THE CODE OF PUBLIC GENERAL LAWS.

53. *When any board of health has had notice of the occurrence within its sanitary jurisdiction of a case of smallpox or any other contagious or infectious disease, dangerous to public health, such board of health shall, within twenty-four hours after the receipt of such notice, notify the State Board of Health of the same.*

Under the provisions of this section the following diseases must be reported *daily:* Smallpox, typhoid fever, diphtheria, scarlet fever, measles, whooping-cough, mumps, acute epidemic cerebrospinal meningitis, acute epidemic anterior poliomyelitis, acute dysentery, influenza, Asiatic cholera and bubonic plague.

## IV. To Whom Should the Report Be Sent?

To many physicians, especially those practicing in the more remote rural districts, this is not infrequently a perplexing question.

In most instances the physician is fairly conversant with the law on the subject. He is thoroughly conscientious and wide awake as to his public duty in this respect, and he is also extremely anxious to comply with the spirit and the letter of the law. But the fact that he does not know the name of the health officer is a stumbling-block, and ofttimes thwarts his good intentions. Then, too, the *personnel* of the town, county and district health officers is constantly changing; truly an unforunate state of affairs. That is why I hesitate about appending herewith a copy of the present list of health officers, but shall do so subsequently, knowing that such a list will be of service, at least for a time. Unquestionably

ATTENTION OF HEALTH OFFICERS IS CALLED TO THE PROVISIONS OF SECTION 53 OF ARTICLE 43 OF THE CODE OF PUBLIC GENERAL LAWS.

53. *When any board of health has had notice of the occurrence within its sanitary jurisdiction of a case of smallpox or any other contagious or infectious disease dangerous to public health, such board of health shall, within twenty-four hours after the receipt of such notice, notify the State Board of Health of the same.*

Under the provisions of this section the following diseases must be reported DAILY: Smallpox, typhoid fever, diphtheria, scarlet fever, measles, whooping-cough, mumps, acute epidemic cerebro-spinal meningitis, acute epidemic anterior poliomyelitis, acute dysentery, influenza, Asiatic cholera and bubonic plague.

Please use only the envelope furnished for this purpose and addressed as follows:

To the Secretary,
State Department of Health,
6 E. Franklin St.,
Baltimore, Md.

And do not use these envelopes for any other purpose.

MARSHALL LANGTON PRICE,
Secretary.

Official,
C. W. G. ROHRER,
Acting Chief, Bureau of Communicable Diseases.

If more blanks are needed, order as C. D. No. 1.

Figure V.—Reverse side of a daily report sheet. It contains a copy of the section of the Maryland law requiring a report within twenty-four hours of all contagious or infectious diseases.

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the time will soon come when all health officers will be required to be full-time men, and they will receive sufficient salary to justify them in devoting all of their time to this work. The tenure of office will also be for as long a period as they shall faithfully perform the duties thereof; otherwise no competent physician would care to relinquish the sure-footed position accorded to him by a substantial private practice in order to take his station upon the rainbow bridge of public health work.

A list of the various health officers throughout the counties of Maryland will next be given. It may be of service to add at this juncture that the corporate limits of the city of Baltimore constitute a separate and distinct public health jurisdiction. Cases of infectious disease occurring therein should be sent to Dr. Nathan R. Gorter, Health Commissioner of Baltimore.[27] My remarks apply only to the entire State of Maryland, exclusive of Baltimore city.

## County and District Health Officers.

| | | |
|---|---|---|
| Allegany County | Dr. J. C. Holdsworth | Midland |
| Anne Arundel County | Dr. Walton H. Hopkins | Annapolis |
| 1st Precinct | Dr. Chas. H. Brooke | Brooklyn |
| 3d Precinct | Dr. Thomas B. Horton | South Baltimore |
| Baltimore County | Dr. Henry M. Slade | Towson |
| 1st District | Dr. Marshall B. West | Catonsville |
| 2d District | Dr. H. F. Shipley | Granite |
| 3d District | Dr. Henry A. Naylor | Pikesville |
| 4th District | Dr. Henry M. Slade | Towson |
| 5th District | Dr. C. E. Fouble | Hampstead |
| 6th District | Dr. Joseph Baldwin | Freeland |
| 7th District | Dr. E. W. Heyde | Parkton |
| 8th District | Dr. Benjamin Benson | Cockeysville |
| 9th District | Dr. Claud C. Smink | Lauraville |
| 10th District | Dr. J. T. Payne | Phoenix, R. F. D. 1 |
| 11th District | Dr. James F. H. Gorsuch | Fork |
| 12th District | Dr. W. E. McClanahan | Highlandtown |
| 13th District | Dr. Frank H. Ruhl | Lansdowne |
| 14th District | Dr. Wm. F. Clayton | Overlea |
| 15th District | Dr. John W. Harrison | Middle River |
| 16th District | Dr. G. C. McCormick | Sparrows Point |
| Calvert County | Dr. I. N. King | Barstow |
| Caroline County | Dr. J. R. Downes | Preston |
| Carroll County | Dr. Chas. R. Foutz | Westminster |
| 1st District | Dr. Franklin H. Seiss | Taneytown |
| 2d District | Dr. Luther Kemp | Uniontown |
| 3d District | Dr. G. Lewis Wetzel | Union Mills |
| 4th District | Dr. Robert F. Wells | Gamber |
| 5th District | Dr. M. D. Morris | Eldersburg |
| 6th District | Dr. John F. B. Weaver | Manchester |
| 7th District | Dr. Chas. R. Foutz | Westminster |
| 8th District | Dr. R. C. Wells | Hampstead |
| 9th District | Dr. Edwin D. Cronk | Winfield |
| 10th District | Dr. Chas. R. Diller | Detour |
| 11th District | Dr. George H. Brown | New Windsor |
| 12th District | Dr. James Watt | Union Bridge |
| 13th District | Dr. Irving D. Chaney | Mt. Airy |
| 14th District | Dr. Daniel B. Sprecker | Sykesville |
| Cecil County | Dr. Jackson Conrey | Chesapeake City |
| Charles County | Dr. Ernest Spencer | Bel Alton |
| Dorchester County | Dr. Victor C. Carroll | Cambridge |
| Frederick County | Dr. James M. Goodman | Frederick |
| Garrett County | Dr. N. I. Broadwater | Oakland |
| Harford County | Dr. H. Lee Hughes | Belair |
| Howard County | Dr. Wm. C. Stone | Ellicott City |
| 1st District | Dr. Wm. C. Eareckson | Elkridge |
| 2d District | Dr. Wm. C. Stone | Ellicott City |
| 3d District | Dr. B. F. Shipley | Alpha |
| 4th District | Dr. J. W. Sims | Glenwood |
| 5th District | Dr. S. A. Nichols | Dayton |
| 6th District | Dr. T. W. Linthicum | Savage |
| Kent County | Dr. George R. Jones | Galena |
| Montgomery County | Dr. C. H. Mannar | Rockville |
| Prince George's County | Dr. John E. Sansbury | Forestville |
| Queen Anne's County | Dr. A. E. Landers | Crumpton |
| Somerset County | Dr. T. Jacob Smith | Princess Anne |
| St. Mary's County | Dr. F. F. Greenwell | Leonardtown |
| Talbot County | Dr. E. R. Trippe | Easton |
| Washington County | Dr. W. D. Campbell | Hagerstown |
| Wicomico County | Dr. Chas. R. Truitt | Salisbury |
| Worcester County | Dr. Paul Jones | Snow Hill |

TOWN HEALTH OFFICERS.

| | | |
|---|---|---|
| Aberdeen | Dr. Chas. R. Kriete | Harford County |
| Annapolis | Dr. Wm. S. Welch | Anne Arundel Co. |
| Brunswick | Dr. Levin West | Frederick County |
| Cambridge | Dr. E. E. Wolff | Dorchester County |
| Crisfield | Dr. C. E. Collins | Somerset County |
| Cumberland | Dr. Francis E. Harrington | Allegany County |
| Easton | Dr. J. B. Merritt | Talbot County |
| Frederick | Dr. Ira J. McCurdy | Frederick County |
| Frostburg | Dr. Timothy Griffith | Allegany County |
| Garrett Park | Through County H. O. | Montgomery County |
| Havre de Grace | Dr. F. W. Steiner | Harford County |
| Hancock | Dr. H. E. Tabler | Washington County |
| Kensington | Dr. Wm. L. Lewis | Montgomery County |
| Lonaconing | Dr. James O. Bullock | Allegany County |
| Laurel | Dr. W. F. Taylor | Prince George's Co. |
| Mount Rainier | Dr. J. C. Ohlendorf | Prince George's Co. |
| Olney | Dr. Chas. Farquhar | Montgomery County |
| Pocomoke City | Dr. R. Lee Hall | Worcester County |
| Takoma Park | Mr. H. E. Rogers | Montgomery County |
| Takoma Sub. Reg | Mr. L. M. Mooers | Montgomery County |
| Westernport | Dr. A. B. Kalbaugh | Allegany County |

Space will not permit me to publish this paper entire in the present issue of the MARYLAND MEDICAL JOURNAL. It is my intention to complete it for the following issue. The importance of this subject[28] is such that it should be brought to the notice of every physician, parent and householder throughout the length and breadth of the State of Maryland.

REFERENCES.

[1]As my apologies for thrusting so uninteresting a paper upon the indulgent reader are identical with those set forth by Dr. Gallup, in the preliminary paragraph of his "Sketches of Epidemic Diseases in the State of Vermont," I shall here quote it entire:

"Should some fastidious critic demand an apology of an obscure individual for publicly approaching the important subjects of the following sheets, he may receive for answer: first, because nothing is more needed; and secondly, because the subject has been neglected by those better qualified."

[2]Right here I shall beg the indulgence of my professional brethren and others while I make a rigid protest against the unpardonable use of the term "doctor," when "physician" is meant. My esteemed friends, the newspaper men, will soon be heralding in striking headlines the fact that quite a large class of "doctors" have been graduated from each of the five medical schools in Maryland. The newspapers are great educators, and none are better than those of our own State; but I sincerely hope that in the future the word "physician" will appear when medical practitioner is meant.

[3]The ten plagues of Egypt, sometimes denominated Pharaoh's plagues, recorded in the book of Exodus, the study of which interested me greatly as a Sunday-school boy, have not outlived their peculiar fascination. Most of them have even survived the 3400 years which intervened between those troublous times and the present. The entire list of these ten plagues is as follows:

1. Water made blood.
2. Frogs.
3. Lice.
4. Flies.
5. Murrain.
6. Boils and blains.
7. Thunder and hail.
8. Locusts.
9. Darkness.
10. Firstborn slain.

[4]In this paper I have used the appellations "State Board of Health" and "State Department of Health" interchangeably, as they are identical in meaning. In the language of the older law this important arm of the State government is termed the "State Board of Health;" when the Bureaus Bill went into effect, on April 13, 1910, for the purposes of that Act the State Board of Health became known under the title and designated "State Department of Health."

[5]During the Middle Ages curious notions prevailed concerning the origin of communicable diseases, especially those assuming pestilential or epidemic pro-

portions. The historian Fort, in his "Medical Economy During the Middle Ages," wrties, as follows, on pp. 348 and 349:

"Pestilential diseases, from the decline of Rome to the termination of the Middle Ages, in whatever form they appeared, were usually preceded by such natural phenomena as attracted notice of contemporaneous annalists, who in many cases made a permanent record of these strange occurrences. Earthquakes, falling mines, inundations, comets, and stains on clothing, houses and utensils, which after the most careful ablution reappeared more vividly than before, belonged to these miraculous events appurtenant to each specific epoch, preceding the approach of epidemics, spreading fear and consternation among all nations.

"As possible precursors of epidemics, the habits of animals, according to high medical philosophers, should be closely observed as an indication of future diseases, it being urged that serpents shunned their usual places, and birds, instead of flying by day, went in flocks at night, on account of atmospheric corruption. During the thirteenth century the nature of comets was sufficiently understood to be described as a 'blazing star or incendiary cloud,' and they performed an important function in prognosticating pestilences or other phenomenal disorders, which were predicted upon a minute astrological scheme to the first years of the fourteenth century."

[6]Now that the woodman's axe is heard in almost every forest throughout the length and breadth of our State, it strikes me as peculiar that so little comment should be made upon the probable effect of such wholesale destruction of our woodlands upon human health, especially in its relation to communicable diseases. The sight of the felling of the giant oaks, centuries old and towering in silent majesty above all the surrounding vegetation, on the tract of land known as Garrett's woods, opposite Clifton Park, on the Harford road, gave rise to these melancholy reflections.

*Harper's Weekly,* one of the greatest of American periodicals, in a recent number, has this to say concerning forests and hygiene, or the value of forest trees from the standpoint of human health:

"We hear much of the importance of the conservation of forests from an economic standpoint, but little is said as to the hygienic value of forests.

"Forests contribute to the general health by breaking the force of steadily blowing winds. They mitigate the heat of summer by the vast amount of evaporation from their leaves that occurs by day. They also promote rainfalls. Thus they check the tendency of the earth to desiccate, which is almost as injurious to health as it is to vegetation.

"Cholera often passes a wooded district and revels in a treeless one. A certain road in India leads for sixty miles through a dense forest. Farther on it runs for ninety miles through a barren plain. Hundreds of persons travel the entire road daily. Now, in the first or wooded section cases of cholera seldom occur, while within the latter it has been of frequent occurrence. One year cholera raged in Allahabad. Soldiers whose barracks were on a hill suffered the most from the epidemic; those in barracks surrounded by four rows of trees much less. But not a single case occurred among the soldiers whose barracks were in a thicket. It was the same the next year."

[7]Lord Byron (1788-1824), in his powerful drama entitled *Marino Faliero,* wrote as follows:

"They never fail who die
In a great cause. The block may soak their gore;
Their heads may sodden in the sun; their limbs
Be strung to city gates or castle walls;
But still their spirit walks abroad. Though years
Elapse, and others share as dark a doom.
They but augment the great and sweeping thoughts
That overspread all others, and conduct
The world at last to freedom."

[8]I am reminded of the following eulogistic little stanza from Michael J. Barry's "The Dublin Nation," which I copied in my note-book twenty-three years ago:

"But whether on the scaffold high,
Or in the battle's van,
The fittest place where man can die
Is where he dies for man."

[9]Many times in qualifying a disease we use the terms communicable, infectious, contagious, transmissible and epidemic interchangeably, and such is the import of their meaning in the present paper. I make this explanation at the outset, so that no confusion will arise when I use the term "communicable" at one place, "infectious" at another, etc., etc. If one were to stick closely to the dictionary definitions, the above plan would hardly be admissible. We shall not, I am sure, take to splitting hairs over mere technicalities; but, keeping our goal in view—recognizing these diseases, reporting them promptly, and curing them, press nobly on to the mark of our high calling.

[10]The contempt for the valetudinarian, expressed by the late Robert Louis Stevenson (b. 1850, d. 1895), himself the most heroic of invalids, is interesting. "To forego all the issues of living in a parlor with a regulated temperature," he writes, "as if that were not to die a hundred times over, and for ten years at a stretch! As if it were not to die in one's own lifetime, and without even the sad immunities of death! As if it were not to die, and yet be patient spectators of our own pitiable change! The permanent possibility is preserved, but the sensations carefully held at arm's length, as if one kept a photographic plate in a dark chamber. It is better to lose health like a spendthrift than to waste it like a miser. It is better to live and be done with it than to die daily in the sickroom." (Robert Louis Stevenson fell a victim to tuberculosis.)

[11]As William Cowper (1731-1800) wrote in Bk. III of his delightful poem "The Task":

"All flesh is grass, and all its glory fades
Like the fair flower dishevell'd in the wind;
Riches have wings, and grandeur is a dream;
The man we celebrate must find a tomb,
And we that worship him, ignoble graves."

In the words of Abd-el-Kader:

"Death is a black camel, which kneels at the gates of all."

[12]Charles Dickens (1812-1870), the man of the ready pen and kindly heart, commenting upon the death of little children, tenderly wrote as follows:

"When death strikes down the innocent and young, for every fragile form from which he sets the panting spirit free, a hundred virtues rise, in shapes of mercy, charity, and love, to walk the world and bless it. Of every tear that sorrowing mortals shed on such green graves, some good is born, some gentler nature comes. In the destroyer's steps there spring up bright creations that defy his power, and his dark path becomes a way of light to heaven."

[13]The above excellent letter was published in the *Medical Record*, New York, March 13, 1880. It was prompted by the regrettable fact, as Dr. Gross himself states, that "so many aspersions have been cast upon the medical profession, even by some of its members, that I considered it my duty to enter the field and fire a shot at the enemy." (See his Autobiography, Vol. II, pp. 94-99.)

[14]Pope, in his Essay on Man, comments as follows on incipient disease:

"As man, perhaps, the moment of his breath,
Receives the lurking principle of death,
The young disease, that must subdue at length,
Grows with his growth, and strengthens with his strength."

[15]Strange to relate, outbreaks of communicable diseases sometimes subserve a most useful purpose. They act as a whip or spur, to urge us to clean up our habitations and put forth our utmost endeavors to make our surroundings salubrious and pleasing. A "clean-up day" is set apart in the city, town or rural community upon whom the rod of affliction has fallen; and the inhabitants emerge from the conflict a sadder but wiser people. This point was observed by Grew, a great writer and physician of three centuries ago. Note what he has to say in his *Cosmol.* c. 2, Sec. 49, 50:

"*Neither are they* [noxious Creatures] *of less use to amend our minds; by teaching us care and diligence, and more wit. And so much the more, the worse the things are we see, and should avoid.* Weesles, kites *and other mischievous animals induce us to watchfulness.* Thistles *and* moles *to good husbandry.* Lice *oblige us to cleanliness in our bodies;* spiders *in our houses; and the* moth *in our clothes. The deformity and filthiness of swine make them the beauty-spot of the animal creation, and the emblems of all vice. The truth is, things are hurtful to us only by accident: that is, not of necessity, but through our own negligence, or mistake. Houses decay, corn is blasted, and the weevle breeds in mault, soonest towards the south. Be it so, it is then our own fault if we use not the means which nature and art have provided against these inconveniences.*"

[16]Thomas Henry Huxley (1825-1895), in his lay sermon "On the Advisableness of Improving Natural Knowledge," makes the following suggestive allusions to plagues and pestilences as affecting the human race:

"This time two hundred years ago—in the beginning of January, 1666—those of our forefathers who inhabited this great and ancient city took breath between the shocks of two fearful calamities: one not quite past, although its fury had abated; the other to come.

"Within a few yards of the very spot on which we are assembled, so the tradition runs, that painful and deadly malady, the plague, appeared in the latter months of 1664; and, though no new visitor, smote the people of England, and especially of her capital, with a violence unknown before, in the course of the following year. The hand of a master has pictured what happened in those dismal months; and in that truest of fictions, *The History of the Plague Year*, Defoe shows Death, with every accompaniment of pain and terror, stalking through the narrow streets of old London, and changing their busy hum into a silence broken only by the wailing of the mourners of fifty thousand dead; by the woeful denunciations and mad prayers of fanatics; and by the madder yells of despairing profligates.

"But, about this time in 1666, the death-rate had sunk to nearly its ordinary amount; a case of plague occurred only here and there, and the richer citizens who had flown from the pest had returned to their dwellings. The remnant of the people began to toil at the accustomed round of duty or of pleasure; and the stream of city life bid fair to flow back along its old bed with renewed and uninterrupted vigor.

"The newly kindled hope was deceitful. The great plague, indeed, returned no more; but what it had done for the Londoners, the great fire, which broke out in the autumn of 1666, did for London; and, in September of that year, a heap of ashes and the indestructible energy of the people were all that remained of the glory of five-sixths of the city within the walls. * * *

"We have learned that pestilences will only take up their abode among those who have prepared unswept and ungarnished residences for them. Their cities must have narrow, unwatered streets, foul with accumulated garbage. Their houses must be ill-drained, ill-lighted, ill-ventilated. Their subjects must be ill-washed, ill-fed, ill-clothed. The London of 1665 was such a city. The cities of the East, where plague has an enduring dwelling, are such cities. We, in later times, have learned somewhat of Nature, and partly obey her. Because of this partial improvement of our natural knowledge and of that fractional obedience,

we have no plague; because that knowledge is still very imperfect and that obedience yet incomplete, typhus is our companion and cholera our visitor. But it is not presumptuous to express the belief that, when our knowledge is more complete and our obedience the expression of our knowledge, London will count her centuries of freedom from typhus and cholera, as she now gratefully reckons her two hundred years of ignorance of that plague which swooped upon her thrice in the first half of the seventeenth century."

[17]Burton, in his Anatomy of Melancholy, says that diseases "crucify the soul of man, attenuate our bodies, dry them, wither them, shrivel them up like old apples, make them as so many anatomies."

[18]INFECTIOUS DISEASES.

Rev. Code 1889, Art. 43, 1882, Ch. 155, Sec. 1.

15. When the health authority of any city or town, or any justice of the peace for any county, is of opinion, on the certificate of a qualified medical practitioner, that the cleansing and disinfecting of any house or part thereof, and of articles therein likely to retain infection, would tend to prevent or check infectious diseases, it shall be the duty of such authority or justice of the peace to give notice in writing to the owner or occupier of such house or part thereof, requiring him or her to cleanse and disinfect such house or part thereof, and articles, within a time specified in such notice; and if the person to whom such notice is so given fails to comply therewith, he or she shall be liable to a penalty of not less than five dollars and not exceeding ten dollars for every day during which he or she continues to make default; and the health authority or justice of the peace, as the case may be, shall cause such house or part thereof, and articles, to be cleansed and disinfected, and may recover the expenses incurred from the owner or occupier in default, as other fines and forfeitures are recoverable; provided that where the owner and occupier of any such house or part thereof is, from poverty or otherwise, unable, in the opinion of such health authority or justice of the peace, effectually to carry out the requirements of this section, such authority or justice of the peace may, without enforcing such requirements on such owner or occupier, clean and disinfect such house or parts thereof, and articles, and the city, town or county in which such house is situated shall defray the expenses thereof.

Ibid., Sec. 2.

16. Any health authority in any city or town, or any justice of the peace for the county, may direct the disinfection or destruction of any bedding, clothing or other articles which have been exposed to infection from any dangerous infectious disorder; provided, that when any person sustains any damage by reason of the exercise of any of the powers of this article, in relation to any matter as to which he is not himself in default, reasonable compensation shall be made by the municipal or county authorities to such person.

[19]The following are the Diphtheria Statistics for the counties of Maryland (the entire State of Maryland, exclusive of Baltimore city) for the past five years:

In 1908 there were 642 cases of diphtheria reported, with 120 deaths.
In 1909 there were 614 cases of diphtheria reported, with 89 deaths.
In 1910 there were 600 cases of diphtheria reported, with 105 deaths.
In 1911 there were 783 cases of diphtheria reported, with 95 deaths.
In 1912 there were 784 cases of diphtheria reported, with 108 deaths.

[20]For example, the recent smallpox outbreak in Allegany county has incurred an expense upon that county totaling $8500.

[21]Derham in his "Physico-Theology," pp. 173-177, points out how life and death through the intervention of disease and decay keep an equal pace. In support of the above he appends a significant table, which I have abridged and included in this footnote.

"By this means (lessening the common age of man to 70 or 80 years) the peopled world is kept at a convenient stay, neither too full, nor too empty. For if men (the generality of them, I mean) were to live now to *Methusalah's* age of 969 years, or only to *Abraham's*, long after the flood, of 175 years, the world would would be too much over-run. Or if the age of man was limited to that of divers other animals, to ten, twenty or thirty years only, the decays then of mankind would be too fast. But at the middle rate mentioned, the balance is nearly even, and life and death keep an equal pace. * * *

"There is a certain rate or proportion in the propagation of mankind. Such a number marry, so many are born, such a number die; in proportion to the number of persons in every nation, county or parish. And as to births, two things are very considerable: One is the proportion of males and females, not in a wide proportion, not an uncertain, accidental number at all adventures, but nearly equal. Another thing is that a few more are born than appear to die in any certain place."

| Names of the Places. | Marriages to Births as | Marriages to Burials as |
|---|---|---|
| England in general | 1 to 4.63 | 1.12 to 1 |
| London | 1 to 4. | 1 to 1.1 |
| Hantshire, from 1569 to 1658 | 1 to 4. | 1.2 to 1 |
| Tiverton in Devonshire, 1560 to 1649 | 1 to 3.7 | 1.26 to 1 |
| Cranbrook in Kent, 1560 to 1649 | 1 to 3.9 | 1.6 to 1 |
| Upminster in Essex, for 100 years | 1 to 4.6 | 1.08 to 1 |
| Frankfort-on-the-Main in 1695 | 1 to 3.7 | 1.2 to 1. |
| Breslau in Silesia, from 1687 to 1691 | | 1.6 to 1. |
| Paris in 1670, 1671 and 1672 | 1 to 4.7 | 1.6 to 1 |

[22]Doctor William Derham (b. 1657, d. 1735), in his volume of lectures entitled "Physico-Theology," delivered at the close of the seventeeth century, has the following to say concerning winds and epidemic diseases in a footnote on p. 17:

"All this is more evident from the cause assigned to malignant epidemical diseases, particularly the plague, by my ingenious learned friend, Dr. Mead; and that is an hot and moist temperament of the air, which is observed by Hippocrates, Galen and the general histories of epidemical diseases to attend those distempers. *Vid. Mead of Poisons, Essay* 5, p. 161. But indeed, whether the cause be this, or poisonous, malignant exhaltations, as others think, the winds are however very salutiferous in such cases in cooling the air and dispersing and driving away the moist or pertiferous vapours."

"*July* 8, 1707 (called for some time after the *Hot Tuesday*), was so excessively hot and suffocating, by reason there was no wind stirring, that divers persons dies, or were in great danger of death, in their harvest-work. Particularly one who had formerly been my servant, a healthy, lusty young man was killed by the heat. And several horses on the road dropped down and died the same day."

[23]On pp. 106 and 107 of Lib. I, Chap. 47, of a very quaint old volume entitled *Synopsis Medicinae,* we find the following statements made in reference to the course usually taken by acute diseases in the old and in the young, in the summer and in the winter, in a wet season and in a dry season:

"Youth hath more strength and natural heat than old age; and so sickness is longer in old people than in young.

"*And the reason is because they more abound with cold humours, have a weaker digestion and decay of natural heat.*

"*Diseases in the spring are less dangerous than diseases in the harvest* (which prove more often deadly). The *summer* shortens sickness, but the *winter* prolongs it. *For in the* summer *the pores being open, the evil humours being stirred up and rarified by the heat of the air, are transpired; but in* winter *being closed and condensed by cold that are retained within.*

"*A dry season is more wholesome,* and not so deadly as a rainy; for dryness resisteth putrefaction, humidity causeth superfluities, excrements and diseases. When the season is constant, the disease is constant; but inconstant, the sickness is the more variable, and a dangerous crisis is to be expected from whence either death or the matter of a new sickness may be looked for.

"*According to the greatness of the cause is the greatness of the disease.* Hence a violent cause against nature shews a great and dangerous or mortal sickness. * * *

"*Gentle and mild diseases* are commonly long; sharp, acute and fierce are ended within about 14 days; extreme hot in about seven days.

"There can be no certain judgment of hot and sharp diseases, by reason that as they on a sudden wax great; so in that extremity they as suddenly end, as well in life as in death. Wherefore while the humors are in motion, suspend judgment, for it is not certain whether they will fall on a noble or ignoble part within or without the vessels."

[24]Bascome, on pp. 92 and 93 of his excellent monograph "History of Epidemic Pestilences," records the following interesting observation:

"It has frequently been observed that epidemic anginas, catarrhs, measles, etc., precede great and destructive plagues and pestilences. It is so in our day. The terrible pestilential cholera of 1817 and subsequent years was preceded by influenza, etc. For the constitution of the seasons by which these diseases are caused becomes increased in its malignancy and powers by the repeated accumulation of the peculiar poison, and it consequently induces the highest gradation of disease, pestilence or plague—all these distempers being essentially similar, differing in appearance only as modified by climate, season, etc., and also by the duration and energy of various efficient causes."

[25]The following melodious lines, pervaded by much sweetness and grace, occur at the opening of Oliver Goldsmith's exquisite poem, "The Deserted Village," which was first published in 1770. They portray the ideal condition which will exist when "the fullness of time is come" and all communicable diseases are reported, when all births and deaths are registered, and when adequate attention will have been given to sewage and drainage. Goldsmith was a medical graduate, and hence his verses are of peculiar interest to the medical fraternity:

"Sweet Auburn! loveliest village of the plain;
Where health and plenty cheered the laboring swain,
Where smiling spring its earliest visit paid,
And parting summer's lingering blooms delayed:
Dear lovely bowers of innocence and ease,
Seats of my youth when every sport could please,
How often have I loitered o'er thy green,
Where humble happiness endeared each scene!"

[26]Owing to continued ill-health, Dr. Price tendered his resignation as secretary to the State Board of Health in January, 1913. It was regretfully accepted by the board at its regular monthly meeting held on January 16, 1913. Dr. John S. Fulton, who had also been Dr. Price's predecessor in office, was unanimously elected at the same meeting to fill the vacancy made by Dr. Price's resignation.

For nearly seven years Dr. Price performed the duties of his office with great credit to himself and lasting benefit to the people of the State of Maryland. Besides his studies in tuberculosis, which are quoted throughout the length and breadth of our land, he succeeeded in bringing about a number of important reforms, systematizing the work of the board and enlarging its sphere of usefulness. Among these innovations might be mentioned the passage of the Pure Food and Drugs Law of Maryland, the organization of the work of the board into bureaus, the daily report of infectious diseases, and the publication of the *Health Officers' Bulletin.*

Dr. Fulton needs no introduction to the people of Maryland. His deeds are known of all men, and his name has become a household word amongst us.

[27]The ordinance of City Council of Baltimore, requiring the report by physicians of cases of smallpox, cholera, yellow fever, malignant diphtheria or scarlet

fever and varioloid within 24 hours after first visit, antedates the State law on this subject by eight years, having been approved by the Mayor on October 24, 1882. On March 20, 1890, it was amended so as to require report of measles, whooping-cough, pseudo-membranous croup and mumps.

[28]Truly, in the words of the immortal poet:

"Ill fares the land, to hastening ills a prey,
Where wealth accumulates and men decay:
Princes and lords may flourish, or may fade—
A breath can make them, as a breath has made;
But a bold peasantry, their country's pride,
When once destroyed, can never be supplied."

6 East Franklin Street.

*(To be continued.)*

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# A COURSE OF LECTURES ON TROPICAL MEDICINE AT THE UNIVERSITY OF MARYLAND.

A COURSE of lectures on tropical diseases in charge of Dr. James A. Nydegger, Surgeon, United States Public Health Service, an alumnus of the university (1892), was instituted at the beginning of the present year. Below we append a memorandum of the course. These lectures have been largely attended by the students and the profession. Authorities on various subjects of this important branch of medicine have delivered, during the course, addresses, notably among which were Dr. Stiles on "Hookworm" and Dr. Carter on "Yellow Fever."

It is understood that this course will be continued by the faculty, and will extend through the entire scholastic year, beginning in October next.

The university is to be congratulated on having instituted this course, and it should be well patronized. The clinical material will be drawn from the United States Marine Hospital, this city, and from elsewhere by special arrangement.

January 13, 1913. Lecture 1, by Dr. Nydegger. Introductory, "History of Tropical Medicine from Ancient Times Down to the Present."

January 20, 1913. Lecture 2, by Dr. Nydegger. "Dysentery, Bacterial, Protozoal, Pseudo."

January 27, 1913. Lecture 3, by Dr. Nydegger. "Amebic Dysentery."

February 3, 1913. Lecture 4, by Prof. Ch. Wardell Stiles, Hygienic Laboratory, United States Public Health Service. "Hookworm." (Illustrated with lantern slides.)

February 10, 1913. Lecture 5, by Dr. Nydegger. "Amebic Dysentery." (Illustrated with lantern slides.)

February 17, 1913. Lecture 6, by Dr. Nydegger. "Trypanosomiasis in General." (Illustrated with lantern slides.)

February 24, 1913. Lecture 7, by Dr. H. R. Carter, United States Public Health Service. "Yellow Fever."

March 3, 1913. Lecture 8, by Dr. Nydegger. "Trypanosomiasis in Man." (Sleeping sickness.)

March 10, 1913. Lecture 9, by Dr. Nydegger. "The Filariases in Man and Animals." (Illustrated with lantern slides.)

March 17, 1913. Lecture 10, by Dr. Nydegger. "Leprosy." (Illustrated with lantern slides.)

March 24, 1913. Lecture 11, by Dr. W. C. Rucker, United States Public Health Service. "Plague." (Illustrated with lantern slides.)

March 31, 1913. Lecture 12, by Dr. Nydegger. "Cholera." (Illustrated with lantern slides.)

April 7, 1913. Lecture 13, by Dr. Nydegger. "Piroplasmosis." (Illustrated with lantern slides.)

April 14, 1913. Lecture 14, by Dr. C. H. Lavinder, United States Public Health Service. "Pellagra." (Illustrated with lantern slides.)

April 21, 1913. Lecture 15, by Dr. Nydegger. "Rocky Mountain Fever." (Illustrated with lantern slides.)

April 28, 1913. Lecture 16, by Dr. Nydegger. "Dengue."

May 4, 1913. Lecture 17, by Dr. Nydegger. "Sprue and Guinea Worm." (Illustrated with lantern slides.)

May 11, 1913. Lecture 18, by Dr. Nydegger. "Spirochetosis." (Illustrated with lantern slides.)

May 18, 1913. Lecture 19, by Dr. Nydegger. "The Relation of the Mosquito to the Malarias and Their Prophylaxis." (Illustrated with lantern slides.)

Clinical Lectures, and Presentation of Cases, and Exhibition of Specimens, a number of, during the course.

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Napoleon's Campaign in Russia Anno 1812. Medico-Historical. By Dr. A. Rose. With illustrations by O. Merte, taken from Yelin "In Russland, 1812." Published by the author, New York, 173 Lexington avenue. 1913. Cloth, $1.50.

The above-mentioned volume, though dealing somewhat with the historical side of Napoleon's Russian campaign, is mostly concerned with the medical aspects. Here is depicted the terrible suffering of that magnificent army of more than 500,000 souls when it entered Russian territory, decimated by the ravages of disease, thirst, hunger and mismanagement, so that only a handful re-entered Europe. From a medical aspect, the book is very interesting, and throws a great amount of light upon the ultimate failure of the expedition. Other than the men were frozen, starved, dysenteric, and generally miserable, the author is unable to throw much light upon any other disease prevalent. He is, however, able to turn the searchlight upon one side of the medical aspect, namely, the utter unpreparedness of the medical corps through lack of supplies, even the most essential of medicines, to meet the emergencies of an extraordinary situation being lacking. As page after page one only reads of the terrible suffering of those noble souls, only here and there broken by the heroic devotion of a member of our profession to his duty, one's pity is aroused and one is brought to a thorough realization that war is, as tersely expressed by Sherman, "Hell."

DR. ADOLPH MEYER,
Director, Phipps Psychiatric Clinic, Johns Hopkins Hospital.

# MARYLAND MEDICAL JOURNAL

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BALTIMORE, MAY, 1913


## THE PHIPPS PSYCHIATRIC CLINIC.

ON Wednesday, April 16, 1913, the Henry Phipps Psychiatric Clinic was dedicated and under the most auspicious circumstances opened for the reception of patients. This Clinic was made possible by the munificence and generosity of Mr. Henry Phipps of Pittsburgh, a far-seeing philanthropist. Since the inception of medicine, insanity has until very recent times been neglected by the profession. Indeed, these unfortunates were relegated to dungeons and considered hopelessly outside the pale of relief. Gradually, through the efforts of a coterie of psychiatrists, the profession as well as the public have been brought to the belief that a large number of the insane can be brought back to normal health, and through proper treatment be made useful and productive members of the community. This happy result was brought about by the realization that insanity is not a stigma, but a disease, and as such should be treated as any other malady rather than by cruelty and restraint. Thus a ray of light and sunshine has been offered the victims of mental disorders, and today, through scientific care, many are constantly being returned to our working forces. Everybody, however, realizes that it is easier to prevent than to cure; that it is in most instances easier to cure a disease in its incipiency rather than in the later stages; but until the establishment of this Clinic this well-recognized feature in other branches of therapeutics has but fragmentarily been applied to mental maladies. Therefore, the opening of the Phipps Clinic inaugurates a new era in brain disorders. Here the border-line cases will be received, observed, watched, and placed under the best surroundings; in fact, every detail in the construction of the clinic has been with an eye to placing the patients under the best

circumstances to conduce to a rapid and complete restoral of the mental faculties. Significant of the importance placed by the world of science upon the establishment of this new undertaking by the Hopkins was the presence at its formal opening of Dr. F. W. Mott of London, Dr. Harvey Cushing of Boston, Dr. William McDougall of Oxford, Dr. Eugene Bleuler of Zurich, Dr. Emmett Jones of Toronto, Professor Heilbronner of the University of Utrecht, besides many other American and foreign physicians of equal reputation, and last, but not least, our own beloved Sir William Osler.

The opening ceremonies extended over a period of three days, at which addresses were made by the foremost scientists touching upon the remarkable strides made during the past decade in those whose minds have become unbalanced, and forecasts for still greater things in the near future.

Under the guidance of Dr. Adolph Meyer, a skilled and trained psychiatrist, we unqualifiedly predict that the Phipps Psychiatric Clinic will not only accomplish the object for which it was established, but that the dreams of the donor will be more than realized. The Clinic has immense possibilities in creating and inaugurating new lines of attacking mental problems. We therefore look for it in the near future to become the clearing-house of advance thought in problems applying to the mental system. We look for it to be the model along which here and there throughout the country similar clinics will be established. We look for it to be the schooling-place for the younger generation in advanced methods as applied to insanity.

As in all the other buildings of the Johns Hopkins Hospital group, the architects in designing the new clinic made it harmonize with the central building. One of the things which impresses the visitor is the fact that environment is going to play a most important part in the treatment. One of the novelties is a miniature theater, furnished in mission style. Here the patients will be entertained by lectures, concerts and other mental relaxers. Every provision has been made to chase away melancholy, depression and kindred evils. There is also a gymnasium equipped sufficiently thoroughly to afford exercise to those able to avail themselves of its use. Everything else is along the same original lines, namely, to make the surroundings comfortable, homelike and cheerful.

Baltimore is to be congratulated on its good fortune of being selected as the home of such a model institution. We predict that it will fulfill its beneficent mission.

## Medical Items.

Dr. Andrew Colin Gillis has resigned as superintendent of Mercy Hospital and has left for Germany, where he will spend some time in study and in attending clinics. He has been superintendent of Mercy Hospital for two years. Dr. Edward T. Smith has been named as his successor.

Dr. Adolph Meyer has named the following men as assistants in the Phipps Psychiatric Clinic of the Johns Hopkins Hospital: Dr. Edward J. Kempf, formerly chief physician at Central Hospital for the Insane, Indianapolis; Dr. Ralph P. Truitt, physician-in-chief of the Insane Department of Bayview Hospital; Dr. Tedrow S. Keyser, assistant physician at Bloomingdale Asylum, New York. The following will be internes: Dr. Roscoe W. Hall, physician at Bayview Hospital; Dr. Louisa Pearce, formerly interne at Johns Hopkins Hospital. Dr. Sydney R. Miller, instructor in clinical medicine at the Johns Hopkins Medical School, will be chief of the clinical laboratory.

The commencement exercises of the Peninsula General Hospital were held on April 12. There were four graduates—Misses Euphemia J. Adamson, Irma Pardee Humphreys, Florence Thevilian and Mary Louise Schoolfield.

Dr. Charles Bagley, Jr., A.B., who has been in Boston for the last six months, recently spent a few days with his father, Dr. Charles Bagley, at his residence, 5 West Chase street. Dr. Bagley will spend the next six months in the Bringham Hospital of the New Howard Medical School in the interest of surgery.

Dr. C. F. Burnam of the Johns Hopkins Medical School gave an interesting lecture on radium in the medical amphitheater of the Johns Hopkins Hospital. Dr. Burnam is associated with Dr. Howard A. Kelly in his work in the medical school and recently bought $23,000 worth of the mineral in Austria for Dr. Kelly.

Dr. Howard A. Kelly recently gave a lecture on radium in Montclair, N. J., and will shortly give another in Des Moines, Iowa.

The annual banquet of the Johns Hopkins Alumni Association of Washington was held at the University Club in that city Wednesday evening, April 16. About 100 graduates attended. W. J. Humphreys of the Weather Bureau acted as toastmaster. Other speakers were Professor John B. Watson of the faculty of Johns Hopkins and Dr. R. S. Woodward, president of the Carnegie Institute. The list of guests included Dr. S. W. Stratton of the Bureau of Standards, Dr. P. H. Pence, acting president of the Maryland Agricultural College: Dr. J. P. McConnell of the Catholic University, Dr. Charles W. Mixter of the University of Vermont, Lewis E. Waring of New York and R. S. Palmer.

Dr. Thomas Fell, the newly-elected provost of the University of Maryland, and president of St. John's College, attended the sessions of the Southern Educational Conference at Richmond, Va., April 14-19. Dr. Fell represented both institutions over which he presides.

Among the noted scientists who came to Baltimore to take part in the Henry Phipps Psychiatric Clinic were Dr. William McDougal of Oxford, England; Dr. Eugene Bleuler of Zurich, Switzerland; Dr. Frederick W. Mott of London, England; Dr. Ottorino Rossi of Sassari, Italy, and Professor Heilbronner of the University of Utrecht, Holland.

Members of the medical profession not only of Baltimore but of the whole country were glad to welcome Sir William Osler, regius profesor of medicine, at Oxford, England, better known to his former co-workers in the Johns Hopkins Medical School as "Dr." William Osler, to Baltimore once more. "Dr." Osler came to take part in the opening exercises of the Henry Phipps Psychiatric Clinic at the Johns Hopkins Hospital. While in the city he was the guest of Dr. Thomas B. Flutcher, 23 West Franklin street.

Mrs. Adolph Meyer, wife of the Director of the Phipps Clinic, gave a dinner at her home, 1012 North Calvert street, Thursday evening, April 17, in honor of Mr. Henry Phipps, the donor of the Phipps Psychiatric Clinic, and Sir William Osler. The guests included Dr. and Mrs. W. S. Thayer, Dr. and Mrs. Campbell, Dr. D. K. Henderson and others.

Dr. A. Duvall Atkins, who has been ill, is said to be much improved.

Dr. William Simon of Catonsville, who has been ill at his home on Edmondson avenue, left recently for Asheville, N. C.

The opening exercises of the Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, took place April 16-18, inclusive. On the first afternoon the session was held at the clinic

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building. Dr. William H. Welch delivered the introductory address. Others addresses were as follows: "The Clinic and the Community" and "Primitive Mechanisms of Individual Adjustment," Dr. Stewart Paton, Princeton, N. J.; "A Word of Appreciation," Henry H. Harlan, president of the board of trustees of Johns Hopkins Hospital; "Specialism in General Hospitals," Sir William Osler, Oxord, England; "The Sources and Direction of Psycho-Physical Energy," Prof. W. F. McDougall; "Autistic Thinking," Prof. E. Bleuler; "Personality and Psychosis," Prof. A. Hoch; "The Personal Factor in Association Reactions," Dr. L. F. Wells; "A Study of the Neuropathic Inheritance in Relation to Insanity," Dr. F. W. Mott; "Pellagra," Prof. O. Rossi; "Psychic Derangement Associated with Ductless Gland Disorders," Prof. H. Cushing; "Demenz Problems," Professor Heilbronner; "Interrelation of the Biogenetic Psychoses," Dr. E. Jones; "Prognostic Significance of the Biogenetic Psychoses," Dr. G. H. Kirby, New York City; "The Anatomical Borderline Between the So-Called Syphilitic and Metasyphilitic Disorders," Dr. C. B. Dunlap, New York City; "Disorders Connected with Anemia," Prof. A. M. Bartlett.

Dr. Henry Barton Jacobs has been re-elected president of the Society of Colonial Wars.

The total expense of the recent smallpox epidemic in Allegany county is said to have been $8000.

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#### MARRIAGES.

Cecil Dabney, M.D., University of Virginia, '10, formerly of Sherwood, Md., now a medical missionary to China, to Miss Frances Cole at Baltimore, March 5, 1913.

James Alexander West, M.D., College of Physicians and Surgeons, '93, of Hancock, Md., to Miss Helen Venable Bridges, at Charlotte, N. C., March 25, 1913.

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#### DEATHS.

It is with great regret that we announce the death of Dr. Prince Albert Morrow, New York University, 1874, at his home in New York City, March 17, 1913, aged 66 years. Dr. Morrow's work on sociological questions has been exceptionally brilliant, and his many medical contribution papers have been widely read.

Joseph G. Waldo, M.D., College of Physicians and Surgeons, 1876, died at his home in Hendersonville, N. C., about March 1, 1913. He was a member of the Medical Society, State of North Carolina.

Hiram H. Gunby, M.D., University of Maryland, '55, died at his home in Crisfield, Md., April 8, 1913, of pneumonia, aged 61 years.

Robert Alfred Moore, M.D., University of Maryland, '91, died at his home in Durham, February 18, 1913, aged 43 years. He was a member of the Medical Society, State of North Carolina.

Christopher Brenner, M.D., University of Maryland, '06, died in Oklahoma City, March 3, 1913, aged 38 years.

William Isaac Reece, M.D., College of Physicians and Surgeons, '93, died suddenly at his home in Adamston, Okla., February 14, 1913, from heart disease, aged 41 years.

Robert Hamilton Campbell, M.D., University of Maryland, '89, died at his home in New Orleans, La., March 17, 1913, from typhoid fever, aged 44 years. Dr. Campbell was formerly of Rockville, Md.

Bruce Thomas, M.D., University of Maryland, '52, died in the American Hospital, Philadelphia, Pa., March 14, 1913, aged 80 years. Dr. Thomas was formerly of Frederick, Md.

Marcellus B. Shupe, M.D., University of Maryland, '85, died at his home, in Connellsville, Pa., March 22, 1913, from the result of injuries received in a runaway accident a year before, aged 49 years.

Jane Elizabeth Bigelow, M.D., Johns Hopkins Medical School, '12, died in a hospital in New York City, March 11, 1913, from scarlet fever, aged 25 years.

James A. Conway (license, Maryland) died at his home in Hoopersville, March 19, 1913. Dr. Conway practiced for many years in Dorchester county.

Hugh Agnus Stewart, M.D., University of Edinburgh, '04, died suddenly, at his home, 347 West Fifty-ninth street, New York City, March 29, 1913, aged 31 years. Dr. Stewart was formerly assistant resident physician at the Johns Hopkins Hospital and assistant professor of pathology at the Johns Hopkins Medical School.

Joel B. Yingling, M.D., University of Maryland, '78, died at his home, 705 Dolphin street, April 14, 1913, aged 65 years.

Owing to lack of space in the June issue, we were unable to continue the article entitled "ON THE REPORTING OF COMMUNICABLE DISEASES," by Dr. C. W. G. Rohrer; same will be published at an early date.

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# THE RELATION OF PURE DRINKING WATER AND PROPER SEWAGE DISPOSAL TO THE HEALTH OF YOUR COMMUNITY.

*By J. A. Nydegger, M.D., U. S. Public Health Service.*

THE supply of a sufficient amount of wholesome water is a fundamental sanitary necessity. We all know a person can live without food for a certain length of time, but who can live long without water? About 50 per cent. of the human body is water. Water enters largely into all of our food, and in order for the proper running of the body a certain amount of water must be taken daily in the form of drink to keep it properly going. In addition, as a drink, we are dependent upon water at all times for maintaining the cleanliness of our bodies and habitations. We would realize more fully, perhaps, how necessary to health and life water is if we were suddenly transported to Africa and set down in the middle of the Sahara Desert, with its miles upon miles of sandy wastes extending as far as the eye can stretch, without a drop of water anywhere. Then when we come to consider how intimately water enters into our food and drink, even into our very existence itself, we are brought to realize how essential it is for the proper preservation of our health that the water we drink should be pure and contain nothing which is injurious.

*All water, from whatever source obtained,* comes from the atmosphere by precipitation in the form of rain or snow. In many places rain or snow water is the only source of supply. This is usually collected as it falls upon the roofs of buildings, and conveyed by gutters and pipes to cisterns located either above or below ground, where it is stored until needed. Wood cisterns,

for water located above ground, are objectionable unless they are carefully looked after and kept clean. Although the water from underground cisterns is pleasantly cool in the summer, and is also guarded against freezing in winter, there are, however, very serious objections to storing drinking water in underground cisterns. These cisterns may be placed within a few feet of privies, and as the walls of neither the cistern or privy are waterproof, it often happens that the drinking water is strongly impregnated with the soluble portions of excrement or the products of decomposition which have passed into the cisterns. If water for drinking purposes is to be stored in çisterns, iron is perhaps the best material for use if the cistern is properly lined with cement or some other impermeable substance to protect the surface. We are told that rain water approaches nearer to purity than any other kind of natural water, and it is the safest of all to drink when proper arrangement for its collection and storage can be made. The use of such water is calculated to limit the disease ordinarily transmitted by water. This is especially the case in time of the prevalence of certain diseases that are carried by water, when infectious material containing the organisms of the disease so frequently finds its way into the general water supply for the community. The uncertainty of the rainfall from year to year, the length of the dry season in many localities, the large size and cost of the cisterns to store a sufficient supply are some of the disadvantages of using water from this source.

*Rivers and small streams* probably supply the larger number of cities and towns in this country with drinking water. Where care is taken to prevent the pollution of the stream above the point where the water is taken, this is usually of fair quality for household purposes. When the river can be tapped near its source, or before a large number of manufacturing establishments can empty their waste products into its current, or before it receives the sewage from a considerable number of the inhabitants living on its banks, the water can generally be regarded as being safe. It is very difficult, however, except in the less settled portions of the country, to find these favorable conditions.

In this country, too, especially in the more thickly settled manufacturing districts, the pollution of rivers has increased to a degree to seriously jeopardize the health of the people who are compelled to draw their water supply from such streams. That the presence of such excessive contamination renders the water unsuitable for drinking or any household purposes appears evident. It is most probable, however, that the most dangerous of the polluting matters are the excreta of human beings, especially of those suffering with disease, the organism of which gain access to the water, such as typhoid fever, etc.

*As a rule, water from fresh-water lakes and deep ponds* is generally to be preferred to river water for drinking purposes. It is less liable to become turbid from time to time, and, except in case

of small ponds, the inflow of sewage is not liable to cause the fouling of the water to any serious extent. When the supply can be drawn from large lakes, as in the case of Chicago and other cities on the Great Lakes of the United States, the water is pure, and no better source can be desired. The water intake pipes, however, in such cases should extend out several miles to a point beyond all possibility of sewage contamination by the city to which the water is to be supplied. (*Note*—To prevent the further pollution of the water of Lake Michigan, adjacent to Chicago, it became necessary not long since to divert the discharge of the sewage of Chicago from Lake Michigan into the Illinois River, a branch of the Mississippi River.) *When the water supply is taken from small ponds,* all sewage and waste products from houses and factories must be rigidly excluded, otherwise diseases attributed to the polluted water are likely to arise among those using the same. (Ponds are often used as sources of ice supply, and while ice from such sources is not used so frequently since the introduction of artificial or manufactured ice, yet ice from such doubtful sources of purity is still used to a considerable extent.) It was formerly supposed that in the process of freezing solid matters in the water were not included in the ice. Recent observations have shown the falsity of this idea, and the ice collected from ponds receiving large quantities of sewage and other impurities also contains a large percentage of impurities. Experiments made at various times show that the purification of water by freezing is in no sense perfect. A considerable number of organisms remain in the ice and retain their vitality, so that when thawed they rapidly multiply. In this way it has been shown that the organisms producing typhoid fever are not entirely destroyed by freezing even after remaining in this condition for a period of 103 days. Hence, in using ice in drinking water, one should know the source of the ice supply.

*Springs and wells supply the water* for most persons not segregated in large communities, such as cities and large towns. Even in the latter no considerable quantity of the water used for drinking and other domestic purposes is derived from wells. Spring water usually comes from a source at a considerable depth below the surface; that is to say, the water has percolated down through thick strata of soil before reappearing at the surface. In its passage through the soil it has lost most of its organic matter, and perhaps has absorbed and holds in solution certain mineral and gaseous constituents. Ordinarily, however, spring water is clear and cool and sparkling, and is in all respects an agreeable and wholesome beverage. (One form of contamination of spring water, however, which must be guarded against is the possibility of surface water coming from a nearby dwelling or stable, gaining access to a spring, especially during the times of rains. This danger can in most instances be guarded against by building around the spring an impermeable wall of concrete, extending to a depth

sufficient to prevent such inflow.) Spring water of known purity is now much in demand in cities and the larger towns for drinking purposes, and its extensive use undoubtedly minimizes to no small degree the prevalence of diseases that are liable to be contracted by the use of impure water. The same may be said of distilled water, now also so extensively used.

The character of well water is often justly open to grave suspicion, being derived from those strata of the soil which are most likely to be contaminated by the products of animal and vegetable decompositions, as the unwholesomeness of the water is proportional to the degree of saturation of the soil with the products of decay. It has been found by experiment that when organic matter, either animal or vegetable in character, largely diluted with water, is allowed to percolate through soil it undergoes a gradual decomposition in the presence of certain minute organisms which have their habitat in the soil. If, however, the soil is saturated with organic matter to excess, and is in the state of concentration, putrefaction takes place, and this change does not take place. (Wells may be divided into shallow, or surface wells, and deep wells. Artesian wells are included in the latter class. Shallow wells are anywhere from a few feet to 50 feet deep. A well is considered deep when 50 feet or more. As a rule, it can be pretty safely stated that the deeper the well the purer is its water liable to be; and, *vice versa,* the shallower the well the greater is the liability of the water being impure. Water from shallow wells, as a rule, is impure and unfit for drinking purposes. The wells we see of this character in towns and in the country are usually lined with stone or brick; and in some of the Southern States, where these articles are less plentiful, boards, or puncheons made by splitting logs, are used for this purpose. These wells are often uncovered and provided with a sweep and bucket attached to a chain or rope for lowering and hauling up the water, or are covered and provided with a pump.)

The following qualities are desirable in pure drinking water: The water should be colorless, transparent, sufficiently aerated, and without odor and decided taste. The mineral constituents, magnesium and lime salts, should not be present in amounts more than to give the water the quality of mere hardness. There should be little organic matter present, and no living or dead animal or vegetable organisms, and no disease-producing organisms or bacteria, and few water bacteria. The water should be almost free from ammonia and nitrous acid, and should contain very small quantities of nitrates, chlorides and sulphates.

The impurities in water may be either in suspension or in solution, or they may be either gaseous or solid, organic or inorganic. Many of the inorganic substances of water are injurious only when present in considerable amounts, as, for instance, the salts of lime and magnesium. These, when present in large amounts, render the water hard and therefore unsuited for domestic use,

and, in addition to this, they are productive of disordered functions of the alimentary canal. Under certain conditions the salts of lime and magnesium are also believed to produce goitre.

The organic impurities in water are of two kinds—dead organic matter of vegetable and animal origin, and living organisms. The amount of dead organic matter commonly found in water is without effect upon health. It serves, however, as a most important indicator of the extent and character of pollution. The organic matter present in water is usually divided into nitrogenous matter and oxidizable organic matter. Neither of these forms of organic matter, as a rule, is injurious to health, and these also are of importance principally as indicators of the nature and extent of pollution.

The living organisms found in water may be either of vegetable or animal origin. The vegetable organisms found in polluted water are of two kinds—the pathogenic and putrefactive bacteria. The bacteria found in polluted water which are of the greatest importance are of the various pathogenic or disease-producing organisms, the most important of which are the typhoid bacillus, the organism of Asiatic cholera, the diarrhea-producing organism, and the dysentery organism. The presence in water of the bacillus coli is also of importance, because it is usually present in the intestinal discharges of man and the domestic animals.

As has been stated, the diseases produced by the presence of specific pathogenic bacteria in drinking water are typhoid fever, Asiatic cholera, dysentery and diarrhea, and are spoken of as water-borne diseases. In addition to these diseases, it is now held that a form of diarrhea is produced also through the presence of certain other organisms found at times in drinking water.

Typhoid fever is a disease from which no part of our country is exempt, and its toll reaches the appalling figures of from 35,000 to 40,000 deaths annually in the United States, and, based on a moderate estimate, nearly one-half million people are attacked annually with this disease in our country. The belief that typhoid fever can be communicated through drinking water is comparatively modern, a fact which was first established about 60 years ago, and which is now hardly questioned by anyone who has studied the different epidemics. It is now considered that few points in the etiology of typhoid fever are so certainly proved as the conveyance of the specific organism by drinking water. The bacillus typhosus, so-called, is the actual cause of the disease, and no water can convey the disease without containing the specific organism. A very large number of severe epidemics of typhoid fever are now on record as having been traced directly to the use of polluted drinking water. The presence of typhoid fever in any community should always lead to an investigation of the nature of the water supply and the removal of the source of the pollution.

No one must get the impression for one moment that typhoid fever can be contracted from no other source than the use of

impure drinking water, for such is by no means the case. But the use of impure drinking water is the chief means whereby it is contracted. Food, flies, fingers, etc., all play their part in the transmission of typhoid fever, but the use of impure drinking water is the chief source from whence it is contracted. The question of the spread of cholera by water is in many respects as well established as the spread of typhoid fever. The relation of polluted water supplies to outbreaks of cholera in certain European cities has been shown most graphically. It is now believed that the bacillus of diarrhea and dysentery in many cases most probably gain entrance to drinking water through sewage and surface water and washings containing the excreta of domestic animals. The bacillus dysenteria, the cause of summer diarrhea in children, is now generally regarded as most probably being caused by being carried in infected water. The greater prevalence of diarrheal disease in hand-fed infants as compared to the breast-fed infants points to the food supply as the source of carrier of the infectious agent. The result of the recent investigations upon the bacterial content of milk indicate that the specific micro-organism of infantile diarrhea gains access to the milk through contaminated water used in cleaning the milk container or water added for purposes of diluting.

The recurrences of these epidemics of typhoid fever bring forcibly to our attention the fact, which was long ago recognized in Europe, that no surface water is safe without final purification, and that an ounce of prevention is worth a pound of cure. As further examples we may cite three of our large American cities—Pittsburgh, Allegheny City and Philadelphia—which have been subject to annual typhoid epidemics, which in point of destruction of human lives exceeded any other agency of death. For the last 14 years, up until some three years ago, when the new filtration plant was put into operation, there were reported in Pittsburgh some 30,000 cases and over 4200 deaths from this disease.

*Filtration* is one of the most satisfactory processes of purifying water. It was formerly supposed that the process was merely a mechanical one by which the particles suspended in the water were removed. While this is undoubtedly true, it is a well-established fact that, besides removing the suspended particles, the filtering process, through properly constructed beds of sand, will diminish the amount of organic matter in the water, while the bacteria are very much reduced in number.

There are a number of methods of purifying water that is polluted, or supposed to be polluted, and thus making it pure and safe to drink. One of these methods is by *sand filtration,* being filtration on a large scale through sand and gravel beds specially prepared, and is resorted to in purifying water in large quantities where used for cities and large towns.

To demonstrate the effectiveness of sand filtration it might be stated that the filter plant at Lawrence, Mass., one of the latest

to be installed, removes on an average of 98.3 per cent. of the bacteria contained in the river water. The average number of deaths in the city from typhoid fever in previous years has been 42 for eight months from October to May, while in the first year after starting the filter there were only 16. Of the 16 who died, nine were known to have used unfiltered canal water for drinking.

*Mechanical Filtration.*—Numerous mechanical filters are now to be had which permit of the rapid filtration of large volumes of water through limited sand areas and generally under considerable pressure. Usually these filters are cleaned by turning the water in the reverse direction, thus washing the filth which has accumulated on the sand into the sewers.

No city, town or community should be satisfied unless it possesses the best water supply. A municipality should be compelled to furnish the citizens with a water supply which does not need house filtration or boiling to render it safe. The insurance companies have brought the matter to a focus by making the quantity and quality of a municipal water supply one of the factors in determining insurance rates. The life insurance rates are sometimes increased if the water is polluted, and the fire rates are increased if the quantity of the general water supply is considered insufficient.

Another class of filters quite extensively used are known as *household filters*. Such filters may be divided into two classes—those which filter all the water supplied to a house, as small forms of the different kinds of mechanical filters already referred to, and those which filter only the portion used for drinking and other household purposes.

The processes of purification of water, aside from filtration, which may be employed are distillation, boiling and treatment by chemical substances. If a water is objectionable merely on account of the bacteria contained in it, and there is danger of contracting one of the water-borne diseases, boiling it for from 10 to 15 minutes will destroy the bacteria completely and will make the water perfectly safe. The importance of boiling all drinking water in times of epidemics of typhoid fever cannot be too strongly emphasized.

*The term sewage* includes not only human excreta, solid and liquid, but also the waste water and impurities coming from human habitations. Such impurities as proceed from manufacturing plants, dye works, gas works, etc., are, strictly speaking, not sewage, though they are frequently spoken of as as such. In all large communities certain arrangements are necessary to secure prompt and sufficient removal of excreta and refuse and used water of households. The daily quantity of sewage coming from a dwelling depends largely upon the amount of pure water supplied for each occupant.

The organic material contained in sewage, even if free from the specific germs of disease, give rise to noxious emanations which,

when inhaled, probably produce a gradual depravement of nutrition that renders the system an easy prey to disease. For this and other reasons it is important that such measures be adopted as will secure the removal of sewage matters from the immediate vicinity of houses as quickly as they have been discharged.

While, from a sanitary point of view, privies of all kinds, whether wells or cesspools, are to be unreservedly condemned, it is not likely they will cease to be built for many years to come.

In some cities and in many of the smaller towns and villages of this country the primitive pit system is still in use. A shallow pit is dug in the ground, over which is erected the privy. When the pit is full, another is dug close by the site of it, and the earth from the new one is thrown upon the excrement in the old one. The privy is then moved over the new pit, and this is used until it, too, becomes full.

*The pail closet system* of removal of excreta has won the support of many distinguished sanitarians on account of its simplicity, its economy, and its meeting with the most sanitary requirements. The excreta, both solid and liquid, are received in a watertight pail, either of wood or metal, and removed once or oftener a week, a clean and disinfected pail being substituted for the one removed.

*Another,* and perhaps better, system than the pail system just *referred* to is the *earth closet system.* Both solid and liquid excreta are received into a watertight pail, and after each use of the closet a quantity of dry earth or ashes is precipitated into the pail.

The establishment of a *water-carriage system* presupposes a constant and abundant supply of water, and necessitates the introduction of the necessary waste pipes for the removal of the sewage itself, and the introduction of a water supply sufficient to keep all closets clean, and flush the drain pipes and keep them free from sewage. When this cannot be obtained, sewers would be likely to prove greater evils than benefits.

*The bacterial treatment of sewage,* or the septic-tank method, has rather recently assumed importance as a simple, practical, efficient and economical means of sewage purification. It depends on the fact that there exists in nature certain non-pathogenic, micro-organisms, which may be divided into two classes—those which are active in the absence of oxygen, air and light, and those which are active in oxygen, air and light, whose functions in life, under the conditions that their names imply, namely, nitrifying bacteria, is to convert the solid portions of excreta and organic matters into gases and liquid forms. This system, briefly described, consists of two tanks, located underground usually, and known as the receiving tank and the discharging tank. The receiving tank is deprived of light and air as much as possible, and the sewage is received into it. Here the sewage remains stationary for a time and the bacteria act on it. The bacteria multiply

with great rapidity, and, acting on the organic matter, the greater part of it is dissolved. The contents of the tank are kept in constant motion by the activity of the bacteria and the resulting gases from the decomposing organic matter. The solid residue left in the receiving tank is small in amount and is harmless. Before leaving the receiving tank the liquid sewage has a slight odor and a brownish-yellow tint. In the second or discharging tank the sewage is acted on by the other class of bacteria, which act best in the presence of light and air, and it is further changed, resulting in a clear filtrate. In the discharging tank is placed coke, clinkers, etc., which serve as material on which the bacteria grow abundantly. These bacteria change the organic matter in the sewage further into harmless nitrites and ammonia.

The final disposal of sewage is a problem that depends for its solution upon the agricultural needs of the country around the city or town.

Another method of final disposal of sewage is known as subsurface irrigation. By this method, instead of directing the sewage over the surface of the ground by means of ditches, the liquid waste is taken into a system of loosely-jointed, porous drains, located from six to twelve inches below the surface of the soil, whence it escapes into the subsoil.

As was stated in the beginning of this paper, there is no more important matter, next after a pure water supply, affecting the health of any community than the proper disposal of sewage. And as we have seen how drinking water is chiefly made impure by sewage pollution, containing the organisms of the water-borne diseases which have been referred to, the prevention of this condition of affairs calls for the attention and careful study on the part of the citizens of a community as well as of the sanitary and health officers thereof.

Address delivered at the semi-annual meeting of the Medical and Chirurgical Faculty of Maryland, at Cambridge, Md., October 12-14, 1912.

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GOLDEN RULES OF GYNECOLOGY: Aphorisms, Observations and Precepts on the Proper Diagnosis and Treatment of Diseases of Women. By George B. Norberg, M.D., Kansas City, Mo., Professor of Diseases of Women and Clinical Gynecology, University Medical College; Gynecologist Kansas City General Hospital; Fellow and ex-President Kansas City Academy of Medicine. St. Louis: C. V. Mosby Company. 1913. Cloth, $2.25.

Every one of the 250 pages of this book contain meat, good red meat, nourishing meat, the basic facts of gynecology in brief, concise, short, pithy, terse sentences. Unlike many textbooks on this subject, the one before us strictly avoids immaterial matter and sticks to that which is useful in gynecologic practice. Thus within so small a compass the author is able to present that which is really worth while to the general man in gynecologic work. Students especially will find it a valuable adjunct to lecture and textbook.

# INTRASPINOUS TREATMENT OF SYPHILIS OF THE CENTRAL NERVOUS SYSTEM.*

*By Charles Metcalfe Byrnes, M. D.,*
Instructor in Neurology, Johns Hopkins University.

Syphilitic diseases of the central nervous system may be divided into two classes. First, those due to active invasion of the nervous tissue by the specific organism; and, secondly, those resulting from the action of the syphilitic toxines—the so-called para-syphilitic diseases; tabes dorsalis, general paresis and spastic paraplegia. Recent observations from the Rockefeller Institute, in which the specific organism has been demonstrated within the brains of those suffering from general paresis have, however, cast some doubt upon the true para-syphilitic nature of this affection. Similarly, opinions concerning the pathology of locomotor ataxia have been modified since the demonstration of the treponema pallidum; and even before its discovery anatomical studies suggested the exclusion of this disease from among the primary affections of the central nervous system. Its position as a true "system" disease in which the posterior columns of the spinal cord are especially susceptible to the circulating toxine becomes less tenable since more careful histological studies in various stages of the disease make it evident that in many cases the posterior spinal ganglia are the seat of an inflammatory condition. This, together with the fact that even in advanced cases of locomotor ataxia not all of fibers of the posterior columns are disintegrated, but only those arising in the cells of the spinal ganglia, tended to support the belief that the disorder is primarily an affection of the sensory nerve roots.

Of the active syphilitic diseases of the nervous system in which organic changes are to be demonstrated the more common pathological states are: (1) endarteritis with its consequent nutritive disturbances; (2) syphilitic exudations about the blood vessels and meninges with gummy deposits; and (3) chronic hyperplastic inflammation with small round cell infiltrations. The lesion may be diffuse or circumscribed, and in most cases presents a combination of the three conditions just enumerated.

It is quite conceivable, then, that cerebro-spinal syphilis (including the meninges) with diffusely scattered lesions may present a variety of clinical manifestations from the vaguest neurasthenic states to the more complex organic disorders; and increasing experience only serves to impress upon me the wisdom of Dr. William Osler's teaching — that a knowledge of tuberculosis, typhoid fever, and syphilis is a knowledge of medicine. With present laboratory methods, however, differential diagnosis has been greatly facilitated, and many otherwise obscure nervous affections can be positively stamped with a luetic label, but in some

*Read before the Medical and Chirurgical Faculty.

cases not until a more exhaustive laboratory study has been made; since not infrequently the usual serum examination alone is quite misleading or inadequate. This failure of the Wassermann serum examination to reveal the whole truth in a series of cases which have recently come to my observation, together with their striking resemblance to the more hopeless condition of multiple sclerosis, and my inability to discard entirely the possibility of a luetic factor, have furnished the basis for my earlier conclusion concerning what appears to be the rational therapy of syphilitic disease of the nervous system. A brief summary of three of these cases is as follows:

All three were males, between the ages of 25 and 37, and all denied venereal infection. In one the only symptom was beginning blindness. Examination revealed slight tremor, advanced optic-atrophy, weakness, diminished abdominal reflex upon one side, and dorsal flexion of the great toe following descending tribal irritation. Wassermann serum reaction negative. The second case showed marked tremor upon exertion, weakness, bladder disturbances, slight changes in speech, and ankle clonus. Wassermann serum test negative. The third case complained of extreme weakness, stiffness in the hands, and difficulty in speaking. There were marked tremor upon extending the hands, definitely hesitating speech, at times nystagmus, and all deep reflexes were exaggerated. He could not write his name because of the tremor, and memory was very defective. Wassermann serum test negative. In all three cases a previous diagnosis of multiple sclerosis had been made. The patients were referred to Dr. Keidel for re-examination of the serum, and a negative report was given in each case. Examination of the spinal fluid, however, showed in each case, slightly increased pressure, marked lymphocytosis, positive Wassermann reaction, and increased globulin content.

These observations led me to believe that failure to obtain a positive serum reaction in these cases was due either to the impermeable nature of the meninges and the absence of free communication between the cerebro-spinal fluid and circulating blood or else the anti-bodies were present in such small quantities that later dilution in the general circulation rendered them apparently inactive. The pronounced clinical symptoms, the definite fixation tests obtained with the spinal fluid, and the microscopic evidences of an active inflamamtory state, however, served to fix more firmly my belief in the impermeability of the spinal meninges. If this were the true explanation, it seemed reasonable to assume that failure to obtain satisfactory therapeutic results by the established methods of administration might be due to the failure of the drug to reach the meningeal spaces, and thus be ineffectual over a large part of the central nervous system which is frequently the seat of syphilitic infiltration. This belief found some support from the observation of Carl D. Camp[1], who had previously published

[1]Camp, C. D. *Jour. Nerv. and Ment. Dis.*, 1912, xxxix, p. 807.

his studies upon the spinal fluid of seventeen patients who had received intravenous administrations of salvarsan. The fluid was examined at varying intervals after the administration of the drug, and in only one case was there even a trace of arsenic, and then only after large and repeated doses. Any attempt to explain these observations must be purely theoretical, since nothing definite is known concerning the physiology of the cerebro-spinal fluid or its relation to the general vascular system. It is probably related to the general lymphatic system, although it is quite clearly established that the central nervous system does not possess a definite system of lymphatic vessels; and the observations of Dr. Bruce tend to disprove the existence of the so-called pericellular and perivascular lymphatic spaces. The meningeal spaces are now regarded as "tissue spaces," rather than true lymphatic structures, while the cerebro-spinal fluid, which is derived ultimately from the blood plasma, is thought to be the product of direct activity of the choroidal plexuses plus filtration, diffusion, and osmosis.

Whatever may be the true explanation, it seems that in cases of cerebro-spinal lues, particularly in the meningeal form, the most promising results ought to be expected from the direct introduction of the drug, either in its original state or in some modified form, into the sub-arachnoid space. With this object in view preparations were begun for the experimental intraspinal administration of mercury, potassium, iodide, and salvarsan upon lower animals to determine what effect they might have upon the central nervous system, when I found that Swift and Ellis[2], of the Rockefeller Institute, had already published the results of such experiments, together with what appeared to be a more rational procedure in the case of human beings. Accordingly, I have adopted their method entirely, and while the time has been too short and my experience too restricted to make any definite statements as to the value of this method, the results have at least been sufficiently encouraging to make me feel that the method will find a place as an accessory therapeutic measure.

The technique is as follows:

(1) After an intra-venous administration of neosalvarsan (preferable to salvarsan, although both have been used) a sufficient amount of blood is withdrawn to obtain 15 or 20 c. c. of serum. The blood must be obtained within two hours after the drug is given, and preferably at the expiration of one hour. With a MacRae needle a sufficient quantity of blood may be readily withdrawn. Although the serum of other neosalvarsan-treated patients has been employed, it is preferable to use that of the patient who is to receive the intraspinal injection.

(2) Allow serum to separate over night, then decant or pipette the serum, and

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[2]Swift and Ellis, N. Y. *Med. Jour.*, July 13, 1912.

(3) Centrifugalize until all cells are deposited.

(4) Dilute the serum to a 40 per cent. solution with $\frac{N}{NaCl}$ and,

(5) Heat at 56° C. for one-half hour (to inactivate the complement, since the spinal fluid contains no complement).

(6) After withdrawing 15 c. c. of spinal fluid, 30 c. c. of this diluted serum, heated to body temperature, are injected. Larger quantities may be injected by withdrawing more fluid and making repeated blood-pressure readings during the administration.

(7) Elevate foot of bed for one-half hour.

It is needless to say that strict asepsis must be observed throughout.

No serum should be used which is not perfectly clear and of straw color. If the serum be slightly blood-tinged, it should be examined microscopically for the presence of blood corpuscles. If this be negative, the slight hemolysis, to which the color is due, will do no special harm, although it is advisable to wait until a clear serum is obtained. Injections may be repeated after an interval of two or three weeks.

*Direct Effect of the Injection.*—No harmful effects have been recorded, and my own observations have shown no untoward symptoms. If the serum has been properly prepared, there are in most cases no ill-effects other than those referable to the lumbar puncture. If, however, the serum is not entirely free of red blood cells, or if there is slight hemolysis, its administration is quite likely to be followed by slight chilly sensations, a moderate rise of temperature (rarely above 100° F.), and shooting pains in the thighs and legs. Sometimes there is nausea or vomiting. These symptoms usually subside within twenty-four hours.

*Clinical Results.*—In the cases reported by Swift and Ellis the most marked results were found in changes in the cerebro-spinal fluid. The cell count was diminished, or became normal; the Wassermann or globulin tests were greatly reduced or normal—changes which had not been effected by the intravenous administration alone—and in some there was decided improvement in the clinical symptoms.

My own experience has been somewhat similar, but is confined largely to clinical observations, since certain inaccuracies in the laboratory examination of the spinal fluid have, for the present, made its examination of little value.

Three cases have been treated up to the present time, and in all there has been definite improvement. One, a patient with tabes dorsalis, in whom there were marked ataxia, bladder disturbances and loss of muscle sense, with numerous parasthesia of the lower extremities, now shows decided improvement in gait, has better control of the bladder, and volunteered the information that he "knows where his feet are." There has also been some diminution of the parasthesia. Wassermann examination of the spinal fluid

is negative. The second case, one of the so-called multiple scleroses, with mental defects, disturbance of speech, and inability to write, has resumed his occupation as street-car conductor, and is to all appearances well. He had received several intravenous doses of neosalvarsan, with some improvement after each, but continued to show marked lymphocytosis and a positive Wassermann test both in the serum and spinal fluid. Following intraspinal treatment the cell count was reduced from 300 to 90, and there was definite improvement in symptoms. A Wassermann examination is now being made. The third patient is at present being treated by Dr. Keidel and myself, and while there has not been sufficient time to make any definite conclusions, there is no question that some improvement has occurred. The patient is a male tabetic, with all the classical symptoms of the disease. There is marked incoordination, and incontinence is such that he must wear a receptacle. He had received several intravenous administrations of salvarsan, with only slight improvement, and while there have been only two intra-spinal doses—the last only a week ago—there is definite improvement in walking, and the patient thinks he has better control of the bladder.

*Conclusions.*—(1) In view of recent studies which tend to emphasize the absence of any active interchange of substances between the cerebro-spinal fluid and the general circulation, and the fact that active cerebro-spinal syphilis, or syphilitic meningitis, does occur with a negative serum fixation test, every case of suspected lues in which there are nervous manifestations should have a careful study made of the spinal fluid if the serum test is reported negative.

(2) Since active cerebro-spinal lues exists in the absence of a negative serum test, it is reasonable to assume that general or systemic lues, may and does exist independently of any luetic involvement of the central nervous system. Accordingly, positive findings in the cerebro-spinal fluid, whatever may be the result of the serum examination, must be evidence of active involvement of the nervous system, and not merely an indication of diffused anti-bodies. In other words, even in the presence of pronounced general luetic infection, if there are no symptoms of nervous involvement, the spinal fluid examination should be negative. Recent studies by Hauptmann[3] tend to support this belief. Forty-seven diseases of various kinds, nine of which were definitely luetic, but in which there was no evidence of nervous involvement, gave a negative reaction in the spinal fluid in every case. On the other hand, in forty-four patients in whom there were nervous symptoms the spinal fluid was positive in every case.

(3) From a study of the changes in the cerebro-spinal fluid, the evident symptomatic improvement following intraspinal treatment, and the anatomical basis for its adoption, it is hoped that it may form a valuable accessory therapeutic measure.

[3]Hauptmann. *Deut. Zeit. f. Nervenheilk,* 1911, xlii.

# THE ADDRESS DELIVERED BY HENRY D. HARLAN AT THE OPENING EXERCISES OF THE PHIPPS PSYCHIATRIC CLINIC, BALTIMORE.

## A WORD OF APPRECIATION.

We are standing at the threshold of a new era for the Johns Hopkins Hospital and the Johns Hopkins University. However glorious the past has been, we look for the coming era to be one of wider influence and larger progress. We have met to receive from its donor, to open and dedicate to the service of humanity, a great building, designed by its gifted architect, to translate into bricks and mortar, wood and stone, marble and steel, the most modern scientific theory of the environment in which those afflicted with mental ills should receive care, planned with the most assiduous attention to detial, provided with every facility, every appliance, every device that human forethought and present knowledge can suggest, thoroughly furnished and completely equipped, and in which no reasonable expense has been spared to provide the means and the opportunity for the advanced study and treatment of mental disorders and for the higher education and training of medical men, students and nurses in this most important specialty.

This clinic, intended, in the words of its founder, for "the better care of patients suffering from mental diseases, especially in the earlier and often curable stage, under conditions similar to those of a general hospital"—with accommodations for an hundred patients, and for a medical staff sufficient to study all cases presented, with its large laboratories for psychology, neuropathology and clinical microscopy as aids to investigation, with its capacity for teaching, with its dispensary or out-patient department for the thorough study of incipient cases in their homes and supervision of home conditions, with its provision for an ample social service to give after-care and skilled supervision of discharged patients, with its unusual facilities for the systematic classification of patients, and for the treatment of acute mental trouble by hydrotherapy, mechanotherapy and continuous baths, with its careful arrangements for recreations, occupations, amusements, industries and music for convalescents—this splendid and costly edifice, with all that it is, with all that it represents, with all that it contains, and with a fund to maintain it during a period of years sufficient to demonstrate its value, is the gift of one modest, thoughtful, generous, sympathetic, far-seeing man—Mr. Henry Phipps of New York.

It is a magnificent gift, magnificent in its conception, magnificent in its size and magnificent in its potentiality for good. It is a gift to the Johns Hopkins Hospital, but it is accompanied by a gift to the Johns Hopkins University, for, coupled with the gift

of the Psychiatric Clinic to the Hospital, there is a gift of a Professorship of Psychiatry to the Johns Hopkins University.

Mr. Phipps shall tell you in his own words why he made these donations. In a letter to the trustees, under date of July 14, 1908, he wrote: "In the short period of its existence—not yet twenty years—the Johns Hopkins Hospital has influenced profoundly every department of the medical profession, and has introduced new standards and new ideals.

"It is a tribute to these and to the men who have carried them out that I establish this new foundation, in the strong hope that in it work of the same high character for the country at large may be done."

These words are worthy of preservation among our most priceless possessions as long as we continue to deserve them.

That Mr. Phipps, a citizen of another State, should have made these Maryland foundations the recipients of such bounty and selected them as instrumentalities through which the beneficent plan that had found a lodgement in his mind for the good of mankind should be wrought out, fills us all with the most profound appreciation and the warmest gratitude. No higher tribute could have been paid to the character of the work which has been accomplished here by those who have engaged in the search for truth, in the advancement of knowledge and the spread of learning, and no greater stimulus or encouragement could have been afforded to the workers in every department of our Hospital and University.

Our gratitude, deep as it is, is not a mere personal sentiment. It is the gratitude of those who recognize both the significance of this gift and the obligation it imposes. A new field of research and endeavor, promising results of supreme importance, has been opened to our staff and students. A great opportunity is present. The problem of administering this great Clinic, of directing its activities, of making it accomplish the objects for which it was designed, is before us. We do not minimize the responsibility of undertaking it, but believing, as we must, that the noble impulse which was born in the heart of Mr. Phipps, and has found such expression, was divinely inspired and will be divinely blessed, we enter upon it with resolute purpose, and we confidently hope that with the aid of the distinguished director who has been chosen and his accomplished assistants, and the co-operation and help of a medical board that has never failed us, there may here be achieved all and more than even you, sir, have anticipated, so that not only may many who enter these walls, facing the darkness and gloom of blighted lives, leave them with hope revived, reason restored and happiness renewed, but also that what is done and taught and learned here may so advance the science of psychiatry that countless others everywhere may be blessed and benefited.

Mr. Phipps, we accept the great building which you have turned over to us today. We cannot thank you sufficiently for the

confidence you have reposed in us, but we are deeply sensible of it and of your liberality, and we trust, sir, that your life may be prolonged many years, during which you may enjoy the rare felicity of beholding some of the benefits to humanity that are to flow from your generosity.

The name of Henry Phipps will have a high place among the benefactors of Baltimore, and, like that of Johns Hopkins, will be remembered with gratitude by unnumbered generations after most of ours are long forgotten.

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# TALK ON RADIUM, DELIVERED AT THE MEDICO-CHIRURGICAL FACULTY, APRIL 11, 1913.

*By H. A. Kelly, M.D.*

It is a pleasure to bring before the members of the society so interesting a subject as the therapeutic use of radium. I cannot, however, take up the medical aspects of this new agent without at first paying a passing tribute to the wonderful discoveries which have emanated from radium in the physical world through the investigations of such physicists as Madame Curie, Rutherford of Manchester, Soddy of Glasgow, Hahn and Marckwald of Berlin, Sir William Ramsay, our own Boltwood of Yale, Bragg of Australia and others.

I recall vividly the visit to this country of one of my German relatives, who, deeply interested in mechanics, was studying at the Baltimore & Ohio Mt. Clare shops. He was not reading the current scientific literature, so I undertook to inform him as to some of the discoveries in the realm of physics connected with radium. He received my announcements with an absolute emphatic, positive and unqualified denial that the so-called discoveries could by any possibility be real, asserting that they were diametrically opposed to all the well-established laws of physics, and he was, therefore, justified in pronouncing them utterly erroneous. Time, however, has not only fully confirmed all that he then so energetically denied, but has added many new discoveries, so creating an entirely new branch of micro-physics and chemistry.

We have, then, in radium a new element which exhibits the usual properties of spontaneous radiation, is self-illuminating and continually throws off countless millions of minute particles, capable, like the X-rays from Crookes' tubes, of traversing all kinds of opaque objects and affecting a photographic plate. This latter property of radium, while interesting and of value in studying its physical characteristics, has as yet no practical value in the field of medicine and therapeutics. Radium, also, by the rays which it throws off, causes many bodies, such as the sulphide of calcium, to become luminous. It also gives out heat spontane-

ously, a small quantity of radium persistently maintaining a temperature of a degree or two above the surrounding atmosphere. This heat-creating property of radium is inherent and inexhaustible. Experiments have shown that 1 gram (15.4 grains) will give off 133 calories per hour. A study of its life-history shows that it lives through a period of 2500 years. In this time, therefore, it develops an energy millions of times greater than that given out by the combustion of the same weight of coal. Radium also has the special property of ionizing the air, so that an electric spark can pass across a gap which it could not jump without the presence of the radium.

Further investigations have shown that this mysterious substance is only one element in a series lying between the two extremes, with uranium at one end and lead at the other; that is, we have here a metal, uranium, one of the heaviest known, with a specific gravity of 238, breaking down by successive explosions and giving off minute particles until, after some 13 changes, it ends in lead, with a specific gravity of 206. One element in this series, called radium F, lasts 202 days; this was discovered by Madame Curie and named "polonium" after her native country. This was discovered before radium. Another element in the series is ionium, discovered by our own Professor Boltwood of Yale University, which has a life of 200,000 years.

The "emanation" (named by Rutherford), of which we hear so much, is a gas produced directly by and a daughter of radium, next in the series below it, while ionium lies next in the series above. It has been found that each time there is a change from one of these elements into another (with three exceptions in the uranium series) a particle of matter is thrown off four times as large as a hydrogen atom. The spectroscope has revealed the fact that this particle of matter is the well-known element, helium, discovered in the sun in 1868 and later found on earth in uranium ores in 1895. So violent is this breaking up of the uranium atom, and of each of these successive elements in this series as they lapse one into the other when the helium atom is given off, that the latter is projected at a rate of 10,000 to 12,000 miles per second, making this the most violent exhibition of force known in nature.

Other radiations from radium are its Beta and Gamma rays. These we use therapeutically. The Beta rays are composed of minute particles, each one 1-1000th the size of an hydrogen atom, heretofore the smallest known. These particles are negatively charged and are called electrons; they are not matter, for they have no weight. They travel with a velocity practically that of light—186,000 miles per second.

The Gamma rays differ from both Alpha and Beta rays in that they cannot in any way be deviated by the most powerful electromagnetic current. They have the marvelous property of penetrating the densest matter, passing readily through one inch of lead and ten inches of iron.

We see that in radium and its congeners we have developed a brand-new science dealing with sub-atomic and radio-active materials, a science standing out by itself, differing utterly and in every conceivable way from any previous branch, and transcending in wonder the dreams of the fairy stories of our youth.

*Medical Properties.*—The medical properties of radium began to be investigated after Curie and Becquerel, the discoverers of the radio-active properties of uranium, had burned themselves by carrying a specimen in the vest pocket. Let me here interpolate that a radium burn only means a reddening of the skin or at most the formation of some superficial vesicles, in no wise harmful, not in any way to be compared to the destructive, dangerous effects of X-ray burns. The investigation of its physiological properties was at once taken up by the French, continued by the English and Germans, and carried on by our own Dr. Robert G. Abbé. These observers soon demonstrated that radium could cure a number of diseases, some of them heretofore intractable, while in a yet greater number of diseases which could also be treated surgically radium effected a cure without operation, scar or disfigurement. Of the superficial cancers of the skin radium will cure about 96 per cent. It will cure lupus, especially erythematosus, and nothing is more remarkable than to see a large, vascular disfiguring nevus driven back into normal tissue, leaving only the smallest sign of its previous presence. Radium acts happily in cancer or sarcoma affecting the eyelid. In a case of Dr. Abbé's, sarcoma of the lower lid simply melted away under its use and the tissues became normal again. In cancer of the inner canthus it will often restore the parts to a normal condition without the sacrifice of the eye demanded by surgery. The effects are not so happy when the cancer affects the mucous surfaces of the mouth or tongue; it will cure some of these cases, but by no means so large a percentage. Large tumors of the parotid are very happily made to disappear or reduced to an operable stage. A large sarcoma of the thigh has been treated by burying the radium in the tumor, and then when the disease had shriveled down to a small mass it was extirpated surgically and the patient saved. In my own hands and those of Dr. Burnam, radium has cured two cancers of the rectum without operation. In one the cure was perfect; in another, over 80 years old, there existed a metastasis in the liver which I could not touch. I have seen a number of cases of recurrent carcinoma of the uterus cured by its use, applications being made through the vagina or by thrusting the radium tubes up into the diseased tissues. It was Dr. Abbé, I believe, who first suggested burying the tubes in the substance of the tumor. In cancers of the uterus, though I have not been able to eradicate the disease, radium had the happy effect of stopping hemorrhage and relieving discharges, and, best of all, relieving all pain.

I feel that it is proper to utter a word of warning, because some of my colleagues are apt to expect too much of radium, and not

infrequently send me hopeless cases in which the pelvis is choked with the cancerous disease, and there is absolutely no hope of effecting anything by treatments of any kind.

It is also my practice after taking out a cancerous uterus, in treating the pelvis through the vagina in the customary way, to insert a tube of radium into the vault of the vagina to irradiate the disease after the operation to destroy any living cancer cells. The amount of radium which I possess is about 500 milligrams, and I can do far more with this amount than it would be possible with the smaller amounts commonly sold, namely, 5 to 10 or 20 milligrams. It is kept in tubes of glass, platinum or aluminum, and used with various screens according as deemed best to cut off certain of the rays. For deep work, where it is desirable to drive the rays far into the tissues, several screens of thin lead are placed about the tube, cutting off the Beta rays and allowing only the Gamma ones to pass through. This is Dominici's plan, and has proved must successful in treating deep-seated malignant affections. I feel that I am hampered in my work with radium by not possessing a considerably larger amount. I want, in all, to secure about 5 grams, or, at the present price, about $500,000 worth.

In the treatment of cancer the treatment is comparable to beating down the walls of a beleaguered city. The larger the cannon balls used the quicker the structure falls.

So, in the future, I hope to do with enormous doses what I cannot accomplish even with the massive doses at my command. There is undoubtedly a field for radium and radio-active substances in the medicine of the future, and each of our medical specialties is discovering a fruitful corner where it can be used with the utmost advantage in curing or ameliorating the ravages of disease.

1418 Eutaw Place.

## Book Reviews.

International Clinics. A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene and Other Topics of Interest to Students and Practitioners. By Leading Members of the Medical Profession Throughout the World. Edited by Henry W. Cattell, A.M., M.D., Philadelphia, U. S. A. Volume LV. Twenty-second Series. Philadelphia and London: J. B. Lippincott Company. Cloth, $2 net.

It is always some time after a discovery before the latest in medicine finds its way into general textbooks. We are therefore compelled to rely upon the journals and periodicals for this infor-

mation if we desire to keep abreast of medical thought. Busy men will find the "International Clinics," issued quarterly, bristling with the last word in medical thought. The present volume is no exception to the rule. Here is to be found articles on diagnosis, treatment, surgery and the specialties by acknowledged authorities. Under such circumstances it is a hard task to pick out any given article or series of articles for especial mention. Perhaps the paper on gout by Labbé, professor at the Hôpital de la Charité, Paris, France, will appeal most to our readers. Doctor Labbé recommends during an acute attack any of the familiar liniments containing chloroform, and such analgesics as pyramidon, phenacetin, and in some cases, even, antipyrine. However, he obtains the best results from the salicylates and colchicum. When employing colchicum he prefers the wine of colchicum seed. If the pain is unbearable or severe, morphia is administered hypodermically. If there is any gastrointestinal disturbance, the patient is placed upon a strict régimé, the diet being limited to chamomile infusion and milk, eggs and meat being absolutely prohibited.

He states that gout in its chronic form is due to the retention of purin bodies and uric acid in the system, and in combating this condition it must be our aim to transform the purin into urea and to dissolve the uric acid and effect its elimination by the kidneys and the skin. There is no doubt that this is the modern conception of the etiology of gout. He highly recommends nucleinic and thymic acids as uric-acid solvents. The writer claims there are two forms of uric acid which present themselves for our consideration—the endogenic, due to metabolic phenomena, and exogenic, due to causes which we ourselves bring about, namely, high living, and which may be avoided by proper diet.

He catalogues a list of remedies which are employed in combating the affection, all of which are pretty well known. Of more than usual interest, however, in the treatment as recently laid down is the employment of inhalations and intravenous injections of the radio-active emanations of certain mineral waters. The author neither approves nor condemns the method.

There are a number of other contributions of more than passing merit—"Epileptic Masks and the Differential Diagnosis of Epilepsy," by William T. Shanahan; "Tuberculosis of the Genito-Urinary Organs," by Arthur Dean Bevan; "X-Ray in Obstetrics: Radiographic Diagnosis of Pregnancies," by Patrick S. O'Donnell; "The Lorenz Operation for Congenital Dislocation of the Hip," by James K. Young, etc.

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Book on the Physician Himself. By D. W. Cathell, M.D., and William T. Cathell, A.M., M.D. Twelfth and Final Edition. Philadelphia: F. A. Davis Company, Publishers.

The first edition of this unique work appeared several decades ago, and it at once took a hold upon the profession by reason of

the importance of its contents and its peculiar and vigorous style. It dealt with a phase of professional life till then overlooked, yet vitally concerned in the doctor's success. It was full of wise counsels regarding the doctor's social, professional and business relations, derived from close contact with the world by a shrewd observer with eyes and ears always wide open. In course of time, under successive editions, it has grown to be a large and handsome work of over 400 pages, with portraits of the authors. With this edition the work of the elder Cathell ceases, and it is not likely that either himself or his son will have anything further to do with it should subsequent editions be called for. It therefore represents the final and mature advice of one who has reached his seventy-fourth year, the rich fruits of a half century of observation and experience. As such it must be regarded as a valuable legacy to the profession for generations to come, "handling judiciously and always in the spirit of high professional honor," as remarked by Dr. William H. Welch, "many topics of interest and importance to the young physician." No graduate in medicine should be without it.

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TEXTBOOK OF OPHTHALMOLOGY. In the Form of Clinical Lectures. By Dr. Paul Roemer, Professor of Ophthalmology at Griefswald. Translated by Dr. Matthias Lanckton Foster, Member of the American Ophthalmological Society; Member of the American Academy of Ophthalmology and Octo-Laryngology. With One Hundred and Eighty-Six Illustrations in the Text and Thirteen Colored Plates. Volume III. New York: Rebman Company. 1913.

With the present volume Foster has completed the translation of this excellent German book. The present volume contains: First, a complete list of illustrations covering all volumes; second, a list of plates (colored) contained in the three volumes; at the end of the volume there is found, third, a most complete index covering the whole work. The work as now completed in three volumes sells at $7.50 net, cloth. After the present small edition is exhausted, the work will be bound in one volume, cloth, of which the price ($7.50) will be the same.

The present volume maintains the same degree of excellence as its predecessors. The contents are copiously and well illustrated, most of the illustrations being original. This volume concerns itself with the pupil (the normal reaction of the pupil, the tracts followed by these reactions, and the method of examination); the most important disturbances in the innervations of the pupil; can a disease in the central nervous system be diagnosed from the derangements of the innervation of the pupil alone? (The behavior of the pupil in diseases of the eye and the action of mydriatics and myotics); pareses of the ocular muscles (the normal functions of the extrinsic ocular muscles and the cardinal symptoms of paresis of one of them, the nerve tracts for the

movements of the eyes, and the first clinical problem in the localization of the focus of disease in a paresis of the ocular muscles, etc.); neurology of the eye (the relations of the trigeminus to the eye and trigeminal neuralgia, paresis of the trigeminus and keratitis neuroparalytica, trigeminus and herpes zoster, etc.); diseases of the choroid; diseases of the optic nerve (neuritis optica and its etiology, simple atrophy of the optic nerve and its causes, diseases of the papillomacular bundle of optic nerve fibers and the etiology of retrobulbar neuritis); diseases of the retina (pigment degeneration of the retina, retinal hemorrhages as diagnostic guides in general diseases, etc.); functional testing of the eye (the numbering and measurement of spectacle glasses, the reduced eye and the visual acuity, the test of the light sense, the genesis of axial myopia, etc.).

Students, general practitioners and oculists seeking a modern, thoroughly reliable text or reference book, will find in Roemer's all and more than they could hope for.

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HANDBOOK OF DISEASES OF THE RECTUM. By Louis J. Hirschmann, M.D., Fellow American Proctologic Society; Lecturer on Rectal Surgery and Clinical Professor of Proctology, Detroit College of Medicine; Attending Proctologist, Harper Hospital, Providence Hospital, and U. J. C. Clinic, etc., Detroit. With 172 illustrations, mostly original, including four colored plates. Second edition, revised and rewritten. St. Louis: C. V. Mosby. 1913. Cloth, $4 net.

It would hardly seem that the first edition of this excellent work could have been improved upon, but since the appearance of that edition proctology, as other branches of medicine, have made radical advances, so that another work along the same general lines was necessary if the reader was to obtain the benefit of the most recent thought. The present edition has been so amplified, simplified and improved that the reader will, in fact, find it a more useful companion than its predecessor. The author has gone into operative technique more thoroughly and added many operations which at that time were not in existence. Here, as heretofore, the writer emphasizes the number of operations which can be satisfactorily performed under local anesthesia. Many new illustrations have been incorporated in the text and the value of radiography in proctology illustrated by numerous plates. A very important lesson which the book is continually driving home is the importance and absolute necessity of proctoscopic examination in suspected rectal diseases, as the profession now has at hand a simple method by which any disease focus can be brought directly under the inspection of the eye, and thus leave nothing for granted. The book also gives a most complete exposition of diagnostic methods as applied to diseases of the rectum and anus. In every way it is an ideal treatise, and should, as formerly, be found of immense service to the general practitioner, student, and even specialist, in gaining an insight into rectal affections.

# MARYLAND MEDICAL JOURNAL

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BALTIMORE, JUNE, 1913

RANDOLPH WINSLOW, M.D., LL.D.

## The President-Elect

of the

## Medical and Chirurgical Faculty



Born October 23, 1852, at Hertford, N. C.

Elementary education in the Academy of his native town.

Collegiate education at Haverford College, from which he received the degree of B.A., 1871, and M.A. in course in 1874.

Medical education at the University of Maryland, graduating with the class of 1873.

Since graduating he has been continuously connected with the teaching staff of his Alma Mater in one capacity or another.

1874-1880, was Assistant Demonstrator of Anatomy.

1880-1886, was Demonstrator of Anatomy.

1880-1891, was Lecturer on Clinical Surgery.

1891-1902, was Professor of Anatomy and Clinical Surgery.

1902 and at present, Professor of Surgery.

1882-1893, Professor of Surgery in the Woman's Medical College.

1884, Professor of Operative Surgery and Topographic Anatomy Baltimore Polyclinic.

Became a member of the Medical and Chirurgical Faculty in 1876, since which he has continuously held his membership.

Vice-President Medical and Chirurgical Faculty, 1896-1897.

Pursued post-graduate studies in Europe in 1883 and 1907.

Has been a prolific contributor to medical journals.

Was the first in Maryland to resect the pylorus for carcinoma, to shorten the round ligaments, 1884, to perform vaginal hysterectomy, 1888, and to operate successfully for gunshot wounds of the intestines, 1893.

He is a bold but conservative surgeon of sound and unerring judgment.

He married December 12, 1877, Rebecca F. Leiper, by which union he has had thirteen children, twelve of whom are alive.

He is a progressive, and has always taken a prominent part in those matters which tended to advance the importance and influence of the University of Maryland. It was at his instigation that the union with the Baltimore Medical College occurred, and largely through his efforts that St. John's College and the Maryland College of Pharmacy became affiliated with the University of Maryland.

He has also taken a prominent part in the affairs of the Medical and Chirurgical Faculty.

## THE NATIONALIZATION OF THE BALTIMORE QUARANTINE STATION.

The discussion of the "quarantine question" at the meeting of the Baltimore City Medical Society, May 16th, fully demonstrated the fact that the sentiment of the physicians and the public of Baltimore city is overwhelmingly in favor of transferring the Baltimore Quarantine Station to Federal control. The public should hastily recognize the fact that quarantine is a national function, of great international importance to public health and public business, and as such its conduct should be promptly delegated to the Federal authorities. In times of threatened crises, when contagious diseases from foreign countries seek to gain admission to this country, the public does not rely on the local health officials, but calls on the Government for aid to fight the foe. Baltimore's quarantine protects the whole country, hence the importance of it being operated to that end by the Government.

The matter of lessening the burden of taxes on the taxpayers of the city is another cogent reason for the transfer. As operated at present, the city appropriates annually about thirteen thousand dollars for the maintenance of this station. Under Government control, there is no charge, and the city would save this unnecessary expenditure; and also the foreign shipping interests, who are unwisely opposing—even preventing the transfer—would save for their stockholders the average annual sum of fifteen thousand dollars.

The Baltimore City Medical Society should heartily endorse this movement, as also the State Board of Health. Baltimore should be the first, and not the last, city to embrace this opportunity.

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# PITUITARY EXTRACT IN OBSTETRICS.

*By J. M. H. Rowland, M.D.,*
Professor of Obstetrics, Baltimore Medical College.

RECENT literature contains many references, some of them very enthusiastic, concerning the use of pituitary extract in obstetrics. Reports have been made by many investigators who have reported on antepartum, intrapartum and postpartum effects. There is not complete agreement concerning the results obtained. We wish to report cases illustrating its effect in the induction of labor, the treatment of abortion and its effect on cases in first and second stages of labor.

*Concerning the Induction of Labor.*—Gottfried[1] finds it efficient when given to induce labor. Humpstone[2] finds it inefficient and cites experiences in 10 cases. Greenbaum[3] finds it of little value in the induction of labor, and claims that it is valuable in direct proportion to the extent of advancement of labor. Fischer[4] induced labor satisfactorily in combination with vaginal tampon in one case of placenta praevia, and also in a case of acute hydramnios. The first case advanced sufficiently to be easily delivered, and the second case terminated spontaneously in 20 minutes. In our list there are four cases illustrating treatment for induction of labor and in the treatment of abortion. They are as follows:

Case 1. Maryland Lying-in Hospital. Hospital No. 6353. M. S., black; age 32. II para-vertex presentation, L. O. A. position, head not engaged, no dilatation of the cervix. February 7, 1913, was given two injections of pituitary extract, 1 c. c. each, with an interval of one and one-half hours. At the end of two hours from the first injection cervix dilated about two fingers. Contractions were so slight as to be scarcely perceptible to patient, causing little discomfort, but perceptible by palpation of the fundus. No further dose was given and all contractions ceased. The administration had no effect upon the maternal pulse rate, blood pressure or temperature. The fetal heart increased about five to eight beats per minute during the two hours in which the pituitary extract was active. On February 22, 15 days later, case was delivered

spontaneously after perfectly normal labor of 10½ hours. Child living, weight 8 pounds and 3 ounces, puerperium uneventful.

Case 2. Maryland Lying-in Hospital. M. R., black; age 21. II para, overdue, slight general contraction of pelvis, vertex presentation, L. O. A. position, cervix soft, admitting tip of index finger. February 7 1 c. c. of pituitary extract was given at 9.25 P. M. Noticeable contractions occurred at 9.33, 9.41, 9.52, 10.15, 10.25 P. M. During this time temperature normal, pulse rate and blood pressure slightly increased. At 10.25 a second injection of 1 c. c. was given. The pains slightly diminished and contractions were not noticeable after 12.25 A. M. Three hours after administration of the first dose all pains ceased. The blood pressure returned to the point from which it started. Fetal heart in this case was not influenced. An examination of the cervix showed, however, dilatation of the size of a silver dollar. Three days later, February 10, bag of waters ruptured and pains began immediately, labor terminating in one and one-half hours. Child living, weight 6¾ pounds, no asphyxiation, no hemorrhage, puerperium uneventful.

Case 3. Maryland Lying-in Hospital. E. F., age 20; I para, white, due March 4. Pelvis normal, vertex presentation, L. O. A. position, fetal heart 144. For several days patient had irregular pains and severe backache at intervals of 15 or 30 minutes. This would last for two or three hours and then stop, beginning again and repeating the performance. One c. c. of pituitary extract with 1-40 gr. strychnine given at 10.20 P. M. March 7; pulse 80, blood pressure 105, fetal heart 140. At 10.40 pains were six minutes apart, gradually increasing in frequency until 11.20, when they were two minutes apart, hard but short and, apparently, not effectual. At 12 o'clock pains began to grow weaker and intervals much greater. At 12 o'clock cervix, which was not dilated at beginning of experiment, was dilated about two fingers, but not thinned out much. Pulse increased to 90, blood pressure increased to 116. Pains ceased shortly after 1 A. M.

Case 4. In service of Dr. Seegar at St. Agnes' Hospital. Mrs. R., age 29; II para, four months pregnant. Severe hemorrhage at intervals for six weeks and continuous bloody discharge. Prior to entering hospital, and for a few hours thereafter, she had severe pains and bleeding. Examination showed dilatation of cervix to two fingers, cervix and vagina packed, pain stopped entirely for five hours. One c. c. of pituitary extract was then given; pains began and increased in severity, pain being referred to the side. Blood pressure before administration, 90; it afterwards rose to 120 and fell again to 100 in 35 minutes after administration. At the end of three hours patient had stool and pains ceased. Because of this, pains were attributed to the desire for stool. When packing was removed next morning fetus was in the vagina. In this case, pituitary extract evidently completed the abortion.

*Administration During the First and Second Stages of Labor.*—

Humpstone[2] finds it useful when dilatation of three fingers or over is present and pains ineffective, and also recommends its use in the second stage to mold and advance the head, claiming added efficiency when given with strychnine. Frees[5] finds it efficient in helping to engage the head, even in cases of mild contraction. He says, after using it in 21 cases, "Pituitrin never disappointed me as a pain-producing agent." Vogt[6] in more than 100 cases found no necessity for forceps delivery, in spite of the high percentage of contracted pelves in Dresden. He found no danger from tetanic contraction and no injury to the fetus. Ross[7] avoided forceps delivery by its use. Nogy[8] found considerable change in the fetal heart, one child having been born badly asphyxiated. We report the following cases:

Case 5. Maryland Lying-in Hospital. Hospial No. 6226. M. S., black; age 24; I para, duration of pregnancy eight and one-half months. Entered hospital after having been in labor for more than 48 hours. Examination showed normal pelvis, head presentation, L. O. A. position, cervix fully dilated, membranes ruptured, head not engaged, pains far apart and weak, pulse 120, blood pressure 100, child in good condition. One c. c. of pituitrin given at 2 A. M. Record of pains and blood pressure follows:

| Time. | Pains. | Blood Pressure. |
|---|---|---|
| 2.10 | Stronger | 105 |
| 2.20 | 1½ minutes apart | 110 |
| 2.30 | 1 " " | 120 |
| 2.40 | 1 " " | 120 |
| 2.50 | 1½ " " | 124 |
| 3.00 | 1½ " " | 116 |

At 3.10 she was delivered with forceps. During the hour she had engaged the head and advanced it to a mid-forceps position, where an easy forceps delivery terminated labor. Child living, no asphyxiation, weight 6¼ pounds, no bleeding, puerperium uneventful.

Case 6. Maryland Lying-in Hospital. Hospital No. 6245. M. A., black; age 29; V para, generally contracted pelvis (sp. 21, cr. 23, troch. 28, ex. conj. 17.5). Previous labors long. One forceps delivery after 36 hours of labor. Was first seen in outdoor clinic when she had been in labor 36 hours, bag of waters having ruptured 15 hours before. Examination showed vertex presentation, L. O. A. position, cervix fully dilated, head engaged, pains weak. Quinine 15 gr. given with no effect. Moved to the hospital at 12 P. M. At this time temperature was 98, pulse 116, blood pressure 126. Pituitrin, 1 c. c. given with 1-40 gr. of strychnine. In 11 minutes strong pains began and at the end of one hour were almost continuous. At 1.10 A. M. vertex showed at vulva and at 1.15 A. M. delivery occurred. In this case blood pressure and pulse were both lower, blood pressure falling from 126 to 110, pulse from 116 to 110. Child living, not asphyxiated, weight 7½ pounds, no hemorrhage, puerperium uneventful.

Case 7. Maryland Lying-in Hospital. Hospital No. 6195. E. K., black, aged 15; I para, contracted pelvis (sp. 22, cr. 24, troch. 29, ex. conj. 17.5, diagonal conj. 9.5), vertex presentation, R. O. P. position; in labor about eight hours, cervix one-half dilated. One c. c. pituitrin with 1-40 gr. strychnine given at 3 A. M. Record of pains, pulse and blood pressure follows:

| Time. | Pains. | Pulse. | Blood Pressure. |
|---|---|---|---|
| 3.00 | Fair | 100 | 120 |
| 3.10 | | 110 | 124 |
| 3.20 | 1 minute apart | 96 | 136 |
| 3.30 | | 90 | 136 |
| 3.40 | almost continuous | 94 | 130 |
| 4.00 | 1 minute apart | 88 | 124 |
| 4.00/4.40 | 1 minute apart | 90 | 124 |

4.40 child delivered; living, not asphyxiated; weight 5 pounds; no bleeding; puerperium uneventful.

Case 8. Maryland Lying-in Hospital. Hospital No. 6401. Mrs. M., white; I para, age 30; normal pelvis; entered hospital in labor (four hours), cervix fully dilated, head engaged. Catheterized specimen of urine showed traces of albumen. Blood pressure 150; fetal heart 144; experimental dose 1 c. c. of pituitary extract given to note effect on fetal heart, pains and blood pressure. No effect on pulse, blood pressure fell a little, fetal heart increased 10 beats or more and pains reduced from five to one and one-half minute intervals, with increased intensity. Delivered in one hour from time of administration. Child living, no asphyxiation, weight 6½ pounds, no bleeding, puerperium uneventful.

Case 9. Maryland Lying-in Hospital. Hospital No. 6153. L. D., black; age 22; slight contraction of the pelvis; full term; in labor about six hours, with weak pains. Cervix one-third dilated, very neurotic; experimental dose of 1 c. c. of pituitary extract with 1-40 gr. of strychnine given at 3 A. M. Record follows:

| Time. | Pulse. | Blood Pressure. | Pains. |
|---|---|---|---|
| 3.00 | 106 | 100 | 5 minutes. |
| 3.10 | 110 | 110 | 1½ " |
| 3.20 | 110 | 110 | 1½ " |
| 3.30 | 116 | 122 | 1½ " |
| 3.50 | 116 | 124 | 2 " |
| 4–4.20 | 110 | 106 | 1 " |
| 4.20–4.45 | 108 | 100 | 1 " |
| 4.45—second dose 1 c. c. | | | |
| 5.00 | 116 | 140 | 1 " |
| 5.15 | 110 | 126 | 1 " |
| 5.30 | 106 | 104 | continuous. |
| 5.45 | 96 | 100 | 1½ minutes. |
| 6.00 | 96 | 100 | 1½ " |

6-8.30 pains remained at 1½ minutes apart.

Pains and blood pressure unchanged from that of 6 A. M.; delivered spontaneously at 8.30. Child living, weight 6 pounds; no asphyxiation; no post-partum hemorrhage; third stage, 10 minutes.

Case 10. Maryland Lying-in Hospital. Hospital No. 6200. Outdoor department. D. J., black; age 23 years; I para; slightly contracted pelvis; L. P. A. position; in labor eight hours; cervix fully dilated, head not engaged. One c. c. of pituitary extract given; pains increased in strength and frequency, no advance of head; child was found to be in bad condition, and upon vaginal examination cord was found prolapsed and pulseless. On account of tonic contractions and bad condition of child, version was thought to be dangerous and useless. Delivered by craniotomy. Child, after craniotomy, weighed 6 pounds. There was considerable post-partum bleeding, which was controlled with douche, ergot and packing. Puerperium otherwise uneventful.

Case 11. Maryland Lying-in Hospital. Hospital No. 6100. M. W., black; I para; age 25; pelvis slightly contracted; R. O. P. position; in labor with complete dilatation at the end of five hours; after two hours more of severe pain, head engaged but then remained stationary for two hours, with weakening pains; 1 c. c. of pituitary extract with 1-40 gr. of strychnine given at 4 A. M. She had then been in labor nine hours. Record follows:

| Time. | Pulse. | Blood Pressure. | Pains. |
|---|---|---|---|
| 4.00 A. M. | 100 | 110 | weak. |
| 4.10 | 100 | 110 | weak. |
| 4.20 | 106 | 116 | strong. |
| 4.30 | 110 | 120 | strong. |
| 4.40 | 114 | 126 | 1 minute apart. |
| 4.50 | 118 | 120 | continuous. |

At 4.52 delivered; child living; no asphyxiation; weight 7 pounds 14 ounces; no post-partum hemorrhage. Third stage, 10 minutes.

Case 12. Maryland Lying-in Hospital. Hospital No. 6267. E. P., black; age 20; I para; pelvis normal, entered hospital. After being in labor 48 hours cervix partially dilated, head presenting, pains poor, stimulation with quinine attempted, no result. Pituitary extract 1 c. c. given and repeated in 30 minutes, with positively no effect upon pain, pulse or blood pressure. Further examination showed a mildly hydrocephalic head, which had been overlooked outside of hospital. Delivered by craniotomy. No hemorrhage. Recovered.

Case 13. Mrs. A. W.; I para; age 25; pelvis normal; seen in consultation with Dr. J. W. Cole; in labor 16 hours; pains about six or seven minutes apart, growing less frequent and diminishing in force. Head on the perineum; vertex visible at vulva at the height of each pain; stationary for one and one-half hours. Woman and child in good condition. 1 c. c. of pituitary extract given by hypodermic injection. In about three minutes patient had continuous pain and child was delivered in about eight min-

utes from the time of injection; placenta separated in about three minutes; no bleeding; puerperium uneventful. Child living; weight 8 pounds; no asphyxiation.

Case 14. Service of Dr. Seegar. St. Agnes' Hospital. Mrs. S., white; age 30; I para; vertex presentation; L. O. A. position. In labor first stage 6 A. M. to 9 P. M.; membrane ruptured spontaneously at 9 P. M.; pains slow and weak, blood pressure 135, pulse 108, at time of administration of pituitary extract (9.45 P. M.) Patient immediately began to have severe contractions, first pain lasting six minutes; severe pains continued at frequent intervals for 20 minutes, then lessening for about 10 minutes, and then increased again to the end of the second stage. Child delivered at 11 P. M. Child living; no bleeding; no asphyxiation. Pulse and blood pressure little changed after adminstration of pituitary extract. A little more than usual bleeding after placenta had been expressed.

The above case was complicated by an ovarian tumor about 8 cm. in diameter adherent in cul-de-sac below brim of true pelvis, and a face or other abnormal presentation was feared. At the end of the first stage the tumor was lifted above the brim, allowing the passage of the child. The tumor evidently made the first stage much longer; the child was not asphyxiated; puerperium complicated by a mild phlebitis on eleventh day.

Case 15. Service of Dr. Seegar. St. Agnes' Hospital. Mrs. A, age 40; VII para; head presentation; L. O. A. position; pelvis normal. This was a very neurotic patient, who in all previous deliveries gave history of having demanded and received chloroform at a very early stage of labor, with a history of long and tedious labor probably in consequence of the administration of chloroform. She went into labor for about six hours and stood the pain very well, but after that began to complain bitterly and demanded chloroform. Examination showed the head not engaged, cervix well dilated. 1 c. c. of pituitary extract was given with the hope that it might shorten second stage. A few minutes after this administration patient had severe and almost continuous pains, and the child was expelled so precipitately that there was scarcely time to prepare for her delivery. The time was so short between the administration of the pituitary extract and the delivery of the child that patient received almost no chloroform. Child was not asphyxiated. No bleeding; puerperium uneventful.

Case 16. Service of Dr. Seegar. St. Agnes' Hospital. Mrs. B., outpatient; age 24; I para; head presentation; L. O. A. position; in labor 12 hours when membranes ruptured spontaneously and pain ceased. One c. c. of pituitary extract given with no effect, no contractions being set up at all. Later on, stimulation by quinine, child was delivered spontaneously after long labor. Child living; no asphyxiation; no bleeding; puerperium uneventful.

Case 17. Service of Dr. Seegar. St. Agnes' Hospital. Mrs. W., age 40; II para; head presenting; L. O. A. position; pelvis normal. History of first labor terminated by instrumental inter-

ference. In labor, first stage lasting eight hours. Membranes ruptured spontaneously. 1 c. c. of pituitary extract given at the end of first stage. Pains variable before administration, but immediately after administration pains became severe and continued strong during the second stage, which lasted 50 minutes. Child living; no asphyxiation; no bleeding; puerperium uneventful.

Case 18. Private practice of Dr. T. W. Keown, who gives me the following report: Mrs. X, age 33; I para. Began having pains afternoon of March 2. I saw her at 10 A. M. March 3. Head presentation; R. O. A. position; no dilatation of the cervix; pains weak. The afternoon of the 3d of March brought no change. There was no change on the morning of March 4. Weak pains continued with cervical dilatation of one finger. On the afternoon of March 4 dilatation of about the size of a quarter; pains weak. Patient was given morphine to produce rest. Result partially successful. Pains continued more or less during the night. On March 5 at 9 A. M. os dilated to size of half dollar, cervix softening, patient in good condition. Quinine sulphate, gr. 12, was given at 10 A. M. At 11.30 pains were not much increased. At 11.40 1 c. c. of pituitary extract was given hypodermically. Within seven or eight minutes pains began, and were so severe that patient was compelled to go to bed. Pains were much harder at 12.05. At 12.05 os dilated. At 2 P. M. os fully dilated. As she had been in labor 60 or 70 hours, I decided to deliver her with forceps, and did so under chloroform anesthesia. Child living; no bleeding; puerperium uneventful.

Case 19. Maryland General Hospital. Mrs. M. B., white; age 30; I para; pelvis normal; head presenting; R. O. P. position; went into labor January 3 at 10 P. M. Pains were weak and ineffectual, though fairly close together during the night of January 3. On January 4, because of ineffectual pains, she was given morphine to get some rest. She obtained about four hours' sleep, when pains again started. This was early in the morning of January 5. During the morning of January 5, until the morning of January 6, pains were fairly good; cervix dilated on January 6 to about size of a silver dollar. Patient and child in good condition. At 4 P. M., January 6, 1 c. c. of pituitary extract was given. Cervix at this time two-thirds dilated, pains good, head well molded, engaged. At 5 P. M. pains had increased, but as patient had begun to be exhausted, she was delivered with forceps; recovery with mild infection in puerperium. Child living; child somewhat asphyxiated; easily resuscitated.

Case 20. Maryland General Hospital. Mrs. R., age 30; I para; pelvis normal; R. O. P. position; limbs slightly edematous; trace of albumen in urine; blood pressure 155. Went into labor February 17 at 1 A. M., with good pains. At first about six minutes apart, and afterwards three or four minutes apart. Dilatation was slow, and at 4 P. M., with no engagement, cervix about one-third dilated; 12 gr. of quinine were given. At 8 P. M. about three-

quarters dilated, head engaged, patient and child showing some exhaustion; 1 c. c. of pituitary extract was given. At this time blood pressure 155, pulse 88. Pains immediately became stronger, but in about five minutes patient complained of headache, and in about 15 minutes had a convulsion. She was immediately delivered with forceps; child dead; weight 8 pounds. There were no more convulsions, and patient made uneventful recovery, the albumen disappearing entirely from the urine in about seven days.

Case 21. Maryland Lying-in Hospital. E. D. White, age 20; II para; pelvis normal; first child delivered spontaneously. Began labor the second time on the evening of March 9. Pains weak and far apart. The midwife in charge of the case was called during the morning of March 10. Pains still weak and far apart. From March 10 to March 11, A. M., she was in labor, with ineffectual pains. On the morning of March 11 a physician was called, who attempted to deliver her with forceps and failed. At 3 P. M. on March 11 she was brought to the hospital. At this time her pulse was 140, temperature 102.8, cervix fully dilated and torn from attempts at forceps delivery. Head beginning to engage at 4 P. M. Quinine, gr. 20, was given; pains improved. Interval between the pains diminished from 10 to 4 minutes apart at 6 P. M. At 9 P. M. head fully engaged, vertex at level of ischial spines, temperature 102, pulse 120. 1 c. c. of pituitary extract given. In a few minutes one long, hard pain brought the head to the perineum, and a few more pains delivered the child, weighing 8 pounds 14 ounces. No perineal tear; no post-partum hemorrhage.

Case 22 (same as case No. 3). White, I para; age 20; pelvis normal; vertex presentation; L. O. A. position.

This woman had been given pituitrin eight days before for the purpose of stimulating some pains which simulated beginning of labor pains; this had caused some dilatation of the cervix, but had not induced labor.

On the morning of March 15 labor pains began with considerable regularity; at 9 A. M. pains were regular and strong, six minutes apart; at 11 A. M. pains were three minutes apart, still stronger; at 12 M., four minutes apart, strong in character; at 12.30, pains not quite so strong, and showing tendency to a greater interval. At 3 P. M. she was given 1 c. c. pituitrin; a few minutes later pains became stronger and bearing down in character, strong, two minutes apart. At 3.30 pains were one and one-half minutes apart, and continued to be strong and close together until 5.18 P. M., when she was delivered. Child weighed 7 pounds; placenta was expressed five minutes after child was born. There was considerable bleeding, which was controlled by hot intrauterine douche. Temperature and pulse were very little affected. Blood pressure arose from 110 at the time of administration to 128 about 30 minutes after, from which time it fell gradually to 100 at the time of delivery. Puerperium normal.

Case 23. St. Vincent's Infant Asylum, care Dr. G. A. Sullivan. Mrs. K.; I para; age 23; white; measurements spines 23, cr. 26, tr. 29, ex. c. diag. c. 10.5, due January 30, 1913. Vertex presentation, L. O. A. position. On February 6 patient went into labor; pains at first slight and far apart; five minutes apart, pains being fairly strong. At this time cervix dilated to about size of half dollar; membranes intact. At this time the fetal heart was 148; mother's pulse between 72 and 80. 1 c. c. of pituitrin was given. In about 10 minutes after pituitrin was given pains began to be closer together, occurring about every one and a half minutes, occasionally appearing to be continuous. While these pains were close together, they did not appear to have expulsive power; the fetal heart increased in rate, reaching its maximum 30 minutes after administration of pituitary extract, when it was 158. After about one and a half hours after administration of pituitrin, patient's pulse suddenly went to 120, but in the course of 10 or 15 minutes fell back again to about 80. At the end of two hours patient had made no progress, pains had become feeble and about 10 minutes apart; patient complained of being tired out, and went to sleep. At 6.30 A. M., February 7, pains again started up, and patient was delivered at 1.30 P. M.

Case 24. Mrs. K.; I para; age 28; apparently six weeks overdue. February 28, at 5 P. M., Barnes bag inserted; 3 A. M. March 1 feeble labor pains until March 2 at 6 A. M., when they became regular and effectual. At 10 P. M. cervix not fully dilated, head presenting, L. O. I. P. position, maternal pulse 64, fetal heart 156. Labor pains at six-minute intervals, lasting about 30 seconds. At 10.18 pituitrin injected; pains began to be stronger and closer together, occurring about every two minutes; fetal heart beat 148, mother's 64; these continued about two minutes apart until 10.54, when they became about three minutes apart. At 11.14 pains were slight, and about three minutes apart, fetal heart about 144, maternal pulse 56; after 11.30 pains began to diminish in intensity and occur at longer intervals; cervix now fully dilated and head low in pelvis, so that an easy delivery by forceps was done.

Case 25. Mrs. G.; white; I para; pelvis normal; age 25. Saw her in consultation when she had been in labor for about 24 hours, with weak and only preliminary pains during the first six or seven hours, and strong contractions during the last 12 or 15 hours. When I saw her she was just recovering from an anesthetic which had been given to attempt forceps delivery; the forceps had been applied and after considerable traction the attempt had been abandoned. The head was at the level of the ischial spines, cervix fully dilated, pains weak, not expulsive. 1 c. c. pituitary extract was given. In about seven minutes she began to have hard pains, which came at intervals of about three minutes at first, and afterwards at intervals of about two minutes. She was delivered in just 30 minutes from the time of administration of the pituitary extract. Child living; no asphyxiation; no bleeding.

Case 26. Maryland Lying-in Hospital. I. G., colored; age 20; I para; pelvis slightly flattened. Labor began at 2 A. M. March 28, 1913. She was admitted to the hospital at 1 P. M. on March 28; pains eight minutes apart, head not engaged. At 3 P. M. pains five minutes apart, and at 6 P. M. pains two minutes apart. At 12.45 A. M., March 29, pains still two or three minutes apart, cervix one-half dilated. At 12.45 and at 1.25 given quinine and strychnine; after this pains were about two minutes apart and harder. At 4 A. M. pains not so hard, farther apart, cervix almost fully dilated, head well engaged, occiput at the level of the ischial spines. At 4.10 A. M. 1 c. c. pituitary extract was given. In about six minutes hard pains began at intervals of about one and a half minutes. Child, weighing 7 pounds 2 ounces, delivered at 6 A. M.; no bleeding; no asphyxiation; puerperium uneventful.

It will be noticed that some of these cases are frankly experimental. In cases 1, 2 and 3 it was given in cases fully due or overdue for the purpose of ascertaining just what effect could be produced in inducing labor. From the record of these cases it would seem that, alone, at least in the doses given by us, it is not effective. In larger doses and given continuously, it might terminate labor. It certainly would be a valuable adjunct in combination with other measures taken to induce labor. In case No. 4 it seems to have been found efficient to complete abortion which had started. It will be noticed also, in cases 1, 2 and 3, that considerable dilatation of the cervix was obtained without severe contractions and without much pain. This seems to be true in the use of pituitary extract in all circumstances, that the pain suffered by the patient is not commensurate with the contractions instituted. Cases 7, 8, 9 and 11 would probably have been delivered without interference.

Nearly all of the cases in which the remedy was given after the dilatation of the cervix or engagement of the head showed either rapid and satisfactory progress resulting in spontaneous labor or advanced the head to a point where easy forceps delivery was possible.

Case No. 4 might have received the remedy much earlier with profit.

Considering our experience in a late case, No. 20, administration in No. 8 might, perhaps, be considered unjustifiable. In No. 20 the blood pressure was 155; in No. 8, 150. Albumen present in each case. In one case the convulsion followed the administration, in the other no unfortunate symptoms arose and the result was quite satisfactory. We shall, thereafter, not give pituitary extract in the presence of any nephritic complication or with blood pressure above 145, though in case No. 8 it will be noticed that the blood pressure was 150, and in this case no increase of blood pressure resulted. The convulsion in case No. 20 might easily have occurred without pituitary extract. The coincidence, if it was

such, will, however, make us careful in the future. Pfeiffer[9] reports unfavorable results in a case of toxemia.

Another question might arise in case No. 10. Was the pituitary extract to blame, in any way, for the prolapse of the cord. Still another question: If pituitary extract has been given without effecting the engagement of the head and a quick delivery is desired for any reason, does the rather tonic contraction present make version undesirable or dangerous?* From observation of the cases under our care, we should hesitate to do a version within two hours after the administration of the remedy.

In case No. 12 the remedy should not have been used in the presence of hydrocephalus, but in this case, as in No. 16, absolutely no effect was produced by the administration of pituitary extract. These are the only cases in which no increase in the intensity of the pains was produced. Even in the cases where exhaustion seemed complete there was some improvement in the intensity of the pains.

It will be noticed that in cases Nos. 21, 25, pituitrin was successful in a single dose after an attempt at forceps delivery had failed.

In cases where the head is on the perineum and stationary, the administration of pituitary extract usually produces so prompt a result that, unless one is acquainted with its action, the delivery may be so precipiate that proper technique may not be observed, or the perineum may be damaged unnecessarily.

Further use of the remedy will, of course, raise other questions and give a more definite knowledge of its use, but enough information is at hand to show that in pituitary extract we have a valuable addition to our obstetrical armamentarium. It will be abused by impatient obstetricians and given in many cases in which there is definite contraindication, but used with good judgment, it will be found very helpful.

In no case, except, possibly, in case No. 10, could the administration of pituitary extract be shown to have damaged the child.

## CONCLUSIONS.

Pituitary extract is efficient to finish abortion, when begun, and to induce labor in conjunction with other remedies. It is inefficient alone.

It will usually cause advancement of the head, if the cervix is half dilated.

Its most brilliant successes are obtained in the last half of second stage, where it will frequently save delivery by forceps.

It probably causes little or no damage to the child.

It should probably not be used in toxic cases, especially those with high blood pressure.

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*Note.—When this paper was read before the Obstetrical and Gynecological Society, Dr. G. W. Dobbin stated that he had already seen in consultation a case in which rupture of the uterus occurred during a version which followed the administration of pituitrin.

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# QUININE IN THE TREATMENT OF INCOMPLETE ABORTION.*

*By Edward Anderson, M.D.*

THE oxytocic properties of quinine have long been recognized by the profession, but its exclusive employment in the treatment of incomplete abortions has never been adopted by anyone, to my knowledge. Ergot in these cases is unsatisfactory, as it causes as forcible contractions of the cervix as any other portion of the uterus, whilst quinine acts chiefly upon the fundus. On being called to a case of this kind, I administer six grains of quinine at once and three grains every hour thereafter until the womb is completely emptied, which never fails to occur in a few hours. This practice I have constantly followed for seven years. Prior to that time I employed the scraping process, usually with the forefinger of the right hand, in removing the adherent placenta. Why I continued this procedure so long I can't conceive, to the great annoyance of my patients, sometimes necessitating the use of an anesthetic and always that of an intrauterine douche. The treatment of incomplete abortions by quinine has many advantages, one of which is the absolute necessity for secrecy, in many cases.

I have more than once had under my care girls of respectable parentage, with retained decomposing products of conception, whose families had rather seen them carried to an untimely grave than have their disgrace made known, even to a physician. I have been afraid to hint at the condition present and dared not even ask for a vaginal examination. There could be no objection to the nature of the case being revealed through the expulsion of the contents of the uterus by quinine, as none but the one in immediate attendance need know anything about it. It is surprising to me that abortionists, if they will continue their nefarious calling, do not employ quinine instead of mechanical means, as it is safe and will always cause the womb to disgorge at any state of

*Read at the meeting of the Medical and Chirurgical Faculty, April 23, 1913.

gestation, particularly if it is preceded by a drastic purgative, such as a compound cathartic pill. A short time since I was called to the bedside of a young married woman who had brought on a miscarriage by introducing a stiff rubber catheter into the uterus. When I arrived I found, as is usually the case, that the fetus had been expelled, but the placenta was still adherent. Fever had set in and she was becoming ill. I gave her quinine, and by the next day she was comparatively well. This woman told me she was taught to use the catheter in this way by her cousin, who lived in a large city and who had, under instruction from a physician, rid herself of the burden of carrying six children to full term in the same way. I have no doubt that many women in our large cities, who are left by abortionists to die of sepsis, might be saved by the timely and proper administration of quinine. Of all the procedures I have adopted since entering the medical profession, the treatment of incomplete abortions by quinine has been the most satisfactory, as it has always been successful.

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METHODS AND MORALS (WORSE THAN H—L) IN MEDICAL PRACTICE, OR THE EVOLUTION OF A BATH ROBE. By A. J. Whitworth, M.D., Formerly Vice-President Association of Physicians and Surgeons of America, Ex-Member Board of Medical Censors, Ex-Member American Medical Association, a Graduate of "Regular" Medicine, an Undergraduate of Homeopathy, a Graduate of Electro Therapeutics, Thirty Years' Experience in the Study and Practice of Medicine and Surgery, a "Bedside" Practitioner and for Many Years a Specialist in Hot Springs, Arkansas; also a Post-Graduate of Osteopathy. Paper. 1913. Hot Springs, Ark.

The above book is written in protest to the practice of women going to male masseurs for treatment without the presence of some other woman of the family. He justly and rightly says that whereas there may be virtuous and good masseurs, still the practice of young girls, young women and, in fact, women of any age, submitting themselves to a rubbing at the hands of masseur, osteopath or any other cult opens the way to gross immorality. As he tersely puts it, both the woman and the man are human and subject to Nature's laws; that the rubbing of the female body, not alone the arms, but in some instances the muscles of the thorax, abdomen and legs, without the presence of a soul and behind locked doors, invites the arousing of the woman's passions. As the writer is an osteopath and cognizant with their practices, the reviewer is forced to the conclusion that the author has taken a just stand and that laws should be enacted compelling those who need massage to go to doctors of their own sex.

# ON THE REPORTING OF COMMUNICABLE DISEASES.

*By C. W. G. Rohrer, M.D.,*
Maryland State Department of Health.

*(Continued from May Number.)*

## V. Work of Other States.

The reporting of communicable diseases and their suppression[29] have been the first functions of every State and Territorial board of health throughout the Union. Indeed, as Assistant Surgeon-General Kerr writes, in his admirable compilation entitled "Organization, Powers and Duties of Health Authorities," published in 1912, "the prevention and control of disease constitutes the prime *raison d'être* of health organization."

The first attempts at public health legislation in the United States were made in the colony of Virginia in 1639, in Massachusetts in 1649, and in New York and New Jersey in 1665. In Maryland the first law intended for the conservation of human life, although not strictly a public health statute, was a bill for killing of crows and wolves, brought by Mr. Aisquith, Mr. Beale, Captain Watts and Mr. Peter Watts from the Upper House of Assembly and laid before the Board or Council at a session of the General Assembly of Maryland held at Annapolis September 5 to October 3, 1704. At that time wolves abounded in prodigious numbers in Maryland. They not only destroyed the young of domesticated animals, but also carried off children; hence the necessity of a law compelling their destruction. Twenty-three years later, at the session of the Legislature which convened at Annapolis on the 10th of October, 1727, the above law was extended so as to include squirrels. In the following year, 1728, it was represented to the Legislature that the people of Somerset county were much oppressed by bears, and a law was passed which gave a reward of 100 pounds of tobacco for each bear killed in that county.

Commenting upon the scope of the above-mentioned early law enacted to promote the public safety of the people of Maryland, the great need of such legislation and the penalty for failure to comply with its requirements, a well-known historian has the following to say:

"At this time (1727) wolves, crows and squirrels were so numerous in Maryland that a law was passed to encourage their destruction. The wolf attacked lambs, pigs, calves, and even children; the crow pulled up the young corn just sprouting from the ground, and large flocks of these birds would light in a cornfield and eat a hundred bushels in a day. Squirrels in hundreds came into the cornfields, and with their sharp teeth would cut the ears of corn at the top, so that rain-water would run in and spoil the

whole ear. They would also visit the grain fields, cut off the heads of the wheat and rye, and carry them off to their den-trees, to be eaten at their convenience. It, therefore, became necessary to pass a law to protect planters from the ravages of these voracious birds and animals, and it was enacted that every master or mistress of a family, or taxable single person, should be obliged, some time in every year, to produce to some justice of the peace in their county three squirrels' scalps or crows' heads for every taxable inhabitant in the family.

"The justice before whom such scalps and heads were brought was obliged to destroy them, that they could not be brought to him a second time. He was also required to report to the county authorities the number of squirrels' scalps and crows' heads brought before him, with the names of the persons who brought them, that it might be known who had and who had not been at work in the execution of the law. If any person failed to do his or her part in killing crows and squirrels, and taking their heads or scalps, he or she was subject to a fine or two pounds of tobacco.

"A reward of two hundred pounds of tobacco was given to any person who might bring a wolf's head before any justice of the peace for the county in which the wolf was killed; and, that the head of the said wolf might not be brought before the justice a second time, he was required to cut out the tongue and crop off the ears."

It is a striking commentary on the above to note that the dismal howl of the gray wolf was last heard in Maryland among the foothills of the Blue Ridge Mountain chain about fourscore years ago. And, *mirabile dictu,* the lithe and active squirrel, abundant even so lately as a generation or two ago, is now protected by law, the open season lasting, in most of the counties, only from September 1 to December 1. A small bounty on a crow's head, however, is still paid in certain sections of the State, whilst a bear, for many years unknown in Maryland in its natural and wild condition, is never seen, except when escorted by traveling showmen.[30]

The first Baltimore health ordinance was passed in 1750. It pertains to a nuisance rather than to communicable diseases, yet one is really a stepping-stone to the other. The ordinance is worded as follows:

"WHEREAS, several persons permit stinking fish and dead creatures or carrion to lie on their lots, or in the street near their doors, which are a very offensive nuisance and contrary to Acts of Assembly, the Commissioners, therefore, order the clerk to put up advertisements to inform such persons that they are to remove the same.

"*Resolved,* That Dr. Wm. Lyon be a committee of one to enforce the same."

In 1766 the first State quarantine law here in Maryland was passed by reason of repeated epidemics of smallpox. In 1769 another quarantine law was passed, and in 1784 still another—a third. In 1790 Dr. George Buchanan suggested to the public the registration of deaths. In the same year Mrs. C. G. Reitman[31] ad-

vertised "that, having duly qualified as a midwife, she hopes, in so prolific a town as Baltimore, to get patronage." In 1797 a new Board of Health for Baltimore was organized by Council, which straightway passed an order to prevent the introduction of pestilential diseases, yellow fever being epidemic at the time.

The first State law requiring the reporting of communicable diseases in Maryland was not enacted until the year 1890,[32] and is cited in the early part of this paper (*Vide* Acts 1890, Chapter 622, "Better Preservation of Public Health"). It requires every physician in the State outside the limits of Baltimore city to immediately notify the Secretary of the State Board of Health of every death occurring in his or her practice from smallpox, cholera, yellow fever, typhoid or typhus fever, diphtheria, or any other disease of a contagious, infectious or epidemic character.[33]

In Section 8, Chapter 312, of the Acts of 1898 the State Board of Health of Maryland is given absolute power in time of threatened epidemic.[34] This portion of the law reads as follows:

"Section 8. Whenever the State Board of Health shall have cause to believe that there is any danger of cholera, smallpox or other contagious or infectious disease invading the State or country, it shall be the duty of the said board to take such action and adopt and enforce such rules and regulations as may be necessary to prevent the introduction or spread of such infectious or contagious disease within this State, and any person or persons or corporations refusing or neglecting to obey such rules and regulations, after due notice thereof, shall be deemed guilty of a misdemeanor, and upon conviction thereof shall be fined not less than fifty nor more than five hundred dollars for every such offense."

At the same time (Section 6, Chapter 312, Acts of 1898) quite stringent regulations were passed concerning the interment of a dead body, especially in cases of death from communicable disease. These are as follows:

"6 E. In all cases of death where no physician was in attendance, the coroner, undertaker, or other person in charge of the interment of such dead body, shall make record as far as possible of the facts required in a certificate of death, and shall forward the same to the nearest registrar or subregistrar within five days. In all cases of death from smallpox, yellow fever, diphtheria, scarlet fever or other contagious or infectious diseases dangerous to public health the certificate of death shall be forwarded immediately, and interment shall be conducted according to the rules of the State Board of Health."

The rules and regulations concerning the disinterment of such dead bodies will next be given:

"6 F. Application for a permit to disinter a human body shall be made by the presentation to the local registrar of a certificate of death properly made and containing the facts required by law for a record of a death. Upon receipt of such a certificate the registrar shall issue a permit for the disinterment. No permit for

disinterment of the body of any deceased person during the months of July and August shall be issued, except when required for the purpose of a legal investigation, nor shall any such permit be issued in cases where death was caused by infectious or contagious disease, except by permission and under the direction of the local board of health."

The Maryland State Board of Health is the seventh oldest in the Union if we make exceptions of Porto Rico (1768), the District of Columbia (1822) and Hawaii (1851). The following is the list of older State boards, with date of their formation and salary of the secretary or executive officer:

STATE BOARDS OF HEALTH OLDER THAN THE MARYLAND BOARD.

| State. | Date authorized. | Salary of Secretary. |
|---|---|---|
| Louisiana | 1855 | $2500 |
| Massachusetts | 1869 | 5000 |
| California | 1870 | 3600 |
| Minnesota | 1872 | 2500 |
| Virginia | 1872 | 5500 |
| Michigan | 1873 | 2500 |
| Maryland[35] | 1874 | 2500 |

We sometimes speak of the Massachusetts State Board of Health[36] as the oldest State Board in the Union, and this statement is substantially correct, because the health body established in Louisiana in 1855, with powers extending all over the State, was in reality only a quarantine board called into existence by the yellow-fever epidemic of 1853. This makes the California State Board of Health the second oldest in the Union, and rightly. The Health Boards of Hawaii and Porto Rico were originally purely quarantine authorities, while the Board of Health of the District of Columbia was a municipal rather than a State health body. According to the latter arrangement, the State Board of Health of Maryland ranks sixth in point of age.

Baltimore was the first city (town it was then) in the United States to have a health officer. There were two of them, Drs. John Ross and John Worthington, known as health officers or quarantine physicians for the port of Baltimore, one for land and one for sea, appointed by his Excellency Thomas Sim Lee, Governor of Maryland. This was in the year 1793. Fear of yellow fever, then alarmingly prevalent in Philadelphia, only 95 miles away, where it slew a total of 4041 persons in less than four months, compelled this action on the part of the Governor. Col. J. Thomas Scharf, one of the greatest of Maryland historians, on p. 267 of his masterly "Chronicles of Baltimore," speaks of this incident as follows:

> "Philadelphia being visited by the 'yellow fever,' Governor Lee interdicted all direct intercourse with that city and the admission of infected vessels, and appointed Doctors John Ross and John Worthington to be health officers; a temporary hospital to be procured for mariners of such vessels, and a duty, confirmed by Congress, of one cent per ton was granted towards the expense."

In the same year (1793), and for the same reason, a Board of Health was formed in Havre de Grace, in Chestertown and in Hagerstown, three thriving Maryland towns.[37]

The yellow-fever epidemic made the citizens of Philadelphia realize the need for a Board of Health, which was created in 1794. In 1797 a Board of Health was created in Newburyport, Mass., and in New York and in Boston in 1799.

In the several States the duty of the physician in regard to reporting communicable diseases is very similar.[38] In Massachusetts, where the State is divided into health districts and a State inspector of health appointed in each district, the method pursued is as follows:

"Sec. 3. *Duties, Inspectors.*—Every State inspector of health shall inform himself respecting the sanitary condition of his district and concerning all influences dangerous to the public health or threatening to affect the same; he shall gather all information possible concerning the prevalence of tuberculosis and other diseases dangerous to the public health within his district, shall disseminate knowledge as to the best methods of preventing the spread of such diseases, and shall take such steps as, after consultation with the State Board of Health and the local State authorities, shall be deemed advisable for their eradication; he shall inform himself concerning the health of all minors employed in factories within his district, and, whenever he may deem it advisable or necessary, he shall call the ill-health or physical unfitness of any minor to the attention of his or her parents or employers and of the State Board of Health."

The statutes of the State of Oregon, the "Beaver State," relating to public health are among the best that it has been my privilege to peruse, and the rules and regulations of the Oregon State Board of Health may be held up as models of their kind.[39] I shall next quote the ones which especially pertain to the notification of communicable diseases:

RULES AND REGULATIONS OF THE OREGON STATE BOARD OF HEALTH.

"It shall be the duty of every practicing physician in the State of Oregon to report to the county health officer, or to the health officer of the municipal corporation in which such diseases are found, within twenty-four hours, by the quickest means of communication, a report of all cases of diphtheria, membranous croup, scarlet fever, cholera, cerebro-spinal meningitis, ophthalmia neonatorum, infantile paralysis, bubonic plague, leprosy, barber's itch and tuberculosis within his jurisdiction.

"It shall be the duty of the superintendent of any State institution, and of the superintendent of any children's home or any other institution of public nature, to report to the secretary of the State Board of Health any of the diseases named in Rule 1.

"It shall be the duty of every physician called to attend a person sick, or suspected of being sick, or in the absence of a physician, every householder, wherein such sickness is found, to report in writing within twenty-four hours thereafter, giving the name and residence of all cases of cholera, yellow fever, smallpox, diph-

theria, membranous croup, scarlet fever, typhus fever, typhoid fever, or bubonic plague, or any other contagious disease, to the county health officer, or other health officer who has jurisdiction in the territory.

"It shall be the duty of the county health officer, when a case of smallpox, yellow fever, typhoid fever, diphtheria, membraneous croup, scarlet fever or measles is reported within his jurisdiction, to place, or cause to be placed, in a conspicuous place, at both front and rear of premises wherein any of the aforesaid diseases occur, a quarantine card or flag, not less than twelve by twenty-four inches, upon which is printed in large letters the name of the disease or the word 'CONTAGIOUS.' If a flag be used, the color shall be, in case of smallpox, yellow; diphtheria, green; scarlet fever, red; bubonic plague, black; and all other diseases, white. It shall be the further duty of the county health officer to prohibit entrance or exit from such house without his written permission.

"Every person attending a person afflicted with smallpox, diphtheria, membranous croup, scarlet fever, or any other contagious disease, shall use every possible precaution to prevent communication of the disease to others. It is urgently advised by the board that physicians, wherever possibly practicable, wear protective clothing when visiting such patients.[40]

QUARANTINE.

"No common carrier or other person shall bring into the State of Oregon any person sick or suspected to be sick with Asiatic cholera, smallpox, yellow fever, typhus fever, diphtheria, membranous croup, scarlet fever, bubonic plague, or any other dangerous, contagious or infectious disease.

"When any railway car, steamboat, sailing vessel or other conveyance coming from a place or locality declared by the State Board of Health to be infected with cholera, smallpox, typhus fever, yellow fever or bubonic plague, or having on board any person or persons affected with any of the above-named diseases, enters any port or place in the State of Oregon, such railway car, steamboat, sailing vessel or other conveyance, and the crew, officers, passengers, baggage, merchandise and freight shall be subject to such inspection and disinfection as may be ordered by the State Board of Health. The expense of such disinfection must be borne by the common carrier or persons bringing such a disease into the State.

"If any person is found on any railway car, steamboat, sailing vessel, or other conveyance, who is sick or expected to be sick with any of the diseases named in Rule 27 (the one immediately preceding), he or she shall be removed by the health authorities within whose jurisdiction such person is found, and isolated and properly cared for until the termination of the disease; and the necessary expense of such isolation and care, if the person so re-

moved is unable to pay the same, shall be a valid claim against and be refunded by the owners, agents or assignees of the railway car, steamboat or sailing vessel, or other conveyance from which said person or persons were removed.

"It shall be the duty of the conductor of any railway car, and of the master or pilot of any steamboat or sailing vessel, and of the driver of other conveyances, going into a place or port within the State of Oregon, to immediately notify, by telegraph or telephone, the secretary of the State Board of Health of any case or suspected case of cholera, smallpox, yellow fever, typhus fever or bubonic plague occurring on such train, conveyance or vessel within the limits of the State of Oregon."

REFERENCES.

[29]Unfortunately, a physician who is punctilious about his public duty in this respect sometimes gets a regular diatribe heaped upon his devoted head, as related in the following quotation from Dr. Rush, it being one of the initial paragraphs of his "Account of the bilious remitting yellow fever as it appeared in the city of Philadelphia in the year 1793."

"My lot in having thus disturbed the repose of the public mind, upon the subject of general health, was not a singular one. There are many instances upon record of physicians who have rendered themselves unpopular, and even odious to their fellow-citizens, by giving the first notice of the existence of malignant and mortal diseases. A physician who asserted that the plague was in Messina in the year 1743 excited so much rage in the minds of his fellow-citizens against him as to render it necessary for him to save his life by retreating to one of the churches of that city."

[30]The few game and wild animals and birds remaining in Maryland should be rigidly protected by law. Only the smaller of the *ferae naturae* any longer survive, an unfortunate condition brought about by the destruction of our forests and other places of concealment, the killing off of the smaller animals and birds upon which they feed, the introduction of modern firearms, and, I might add, the inordinate greed of the pot-hunter. The wild turkey and the passenger pigeon, once so abundant, are now extinct in this State; while the whip-poor-will is only found in certain wooded sections. If the poet Longfellow were to come back to earth again, there is scarcely a spot in Maryland upon which he could stand and truthfully exclaim: "This is the forest primeval."

[31]There were at least two midwives who plied their trade in Maryland at an earlier date than Mrs. Reitman. These were Mrs. Hughes, at the time the only midwife to the English, and Mrs. Littig, at the time the only one to the Germans, both of whom flourished as early as the year 1752. Then Baltimore town had a population of only 200, the town and county 17,238, and the entire province of Maryland 152.564.

[32]It is difficult to conceive of just how our forefathers managed to exist without definite public health laws and regulations and individuals empowered to enforce them. Epidemic diseases prevailed in those primitive days very much after the manner of the present time. But there were several important points in favor of these hardy pioneers. For example, the country was then much more sparsely settled, towns, villages and communities not yet having been projected to any very great extent. The people lived more in the open, thus giving the fresh air and sunshine—Nature's best disinfectants—ample time to act. The distance to be traversed between the respective homes was usually great, and the means of transit but slow, so that very little, if any, of the contagious principle could remain until the end of the journey was reached. Then, too, our early ancestors and their immediate descendants were blessed with stronger constitutions than we of today.

[33]The following highly suggestive note appears at the end of an excellent paper by Charles Fayette Taylor, M.D., of New York, entitled "Spinal Irritation; or, the Causes of Backache Among American Women," reprinted from the Transactions of the Medical Society of the State of New York for 1864. Taylor's paper was written fifty years ago; and I am quoting from it to illustrate the fallacy of proclaiming the increased prevalence of infantile paralysis as a new thing. He wrote:

"I wish to call the attention of the profession to the alarming increase of *infantile paralysis*. The explanation can be found only in the irritable and susceptible nervous and feeble organic systems which have been developed in parents and transmitted to children, as is always the case, in an exaggerated form. These cases of paralysis in small children occur almost entirely among the highest and most intellectual classes, and very many of them are children of mothers who have suffered from backache from girlhood up. With such antecedents and such a temperament, no wonder that the slightest causes are liable at any time to overwhelm them with some form of paralysis."

[34]Donaldson, on pp. 17 and 18 of his "Review of the Present Systems of Medicine and Surgery of Europe and America," in his section entitled "A Brief His-

tory of Epidemic Pestilences from the Earliest Ages to the Present Day," writes as follows concerning the origin and nature of pestilences:

"The nature of the diseases, of which we now intend to give the history, has lain in obscurity and darkness since the beginning of the world, and to say that we design in the following relation of facts on record to unfold the mystery would be deemed a mere presumption; but we are not concerned what the invidious will imagine and presume in repugning our laudable endeavors; we have determined to disclose the secret for the good of man. Those pestilences of which we speak are the most common and deadly of all diseases incident to all living animals in the wide dominions of nature. They infest the inhabitants of the world at times, certain seasons and different periods; molest the inhabitants of countries, regions, districts, places, cities and villages, and originate in all climates of the earth, especially of the torrid and temperate zones. They sometimes seize whole nations universally at the same time, season and period; sometimes attack a nation or a people partially, and progressively affect them all in their remotest habitations; and at other times they prevail among the inhabitants of particular provinces and cities, according to the facts recorded in the annals of medicine. Hence physicians have been led to call them *Pandemic, Epidemic, Endemic* and *Sporadic* pestilences or diseases from the universal, the general, the particular and casual prevalence or occurrence of such pestilences among the people of nations, kingdoms, provinces and cities."

[35]The salary of the secretary to the State Board of Health of Maryland is small compared with that of other States similarly situated as to wealth, position and natural resources. Massachusetts is but two-thirds the size of Maryland, yet it pays its State Board of Health secretary $5000 per annum; Connecticut, scarcely one-half as large, pays $3000; while Pennsylvania pays $10,000.

[36]The Massachusetts State Board of Health, with Dr. Henry P. Walcott, chairman, and Dr. Mark W. Richardson, secretary, is still held up as a model after which other State boards would do well to copy. The Louisiana State Board of Health, with so able and energetic a man as Dr. Oscar Dowling for president, is likewise doing excellent work, and its influence, like that of the Massachusetts board, is felt far beyond the limits of the State lines.

[37]Formerly much speculation existed as to the cause of plagues and pestilences, that is, of communicable diseases prevailing as sweeping epidemics. Such an instance occurred in Norfolk, Va., in 1855, when yellow fever was epidemic in that thriving seaport city. It is interesting to add that twenty-six refugees from Norfolk died of yellow fever in Baltimore, but not a single resident of Baltimore contracted the disease. Concerning the supposed origin, the Rev. George D. Armstrong, D.D., pastor of the Presbyterian Church of Norfolk, in his sermon entitled "The Lesson of the Pestilence," preached on Sunday, December 2, 1855, made the following statements, which opinions were current at that time:

"Some have said its coming is to be traced to the filthy condition of our city during the early months of the summer; and I have read, in papers published at a distance, of numbers of new wharves, and a long causeway, all filled in with rotting wood and mud from the river bottom, and to these has the fever been traced as its origin. Speaking among you who best know the facts in the case, I say our city is one of the cleanest, best paved cities on the whole Atlantic seaboard, and during the early summer its streets and alleys were as clean as usual. Of the long causeway I know nothing; and whilst a large, new wharf has been in process of construction, the wharf is in the very opposite part of the city from that in which the fever first began to prevail. And further: In the neighboring town of Portsmouth, where the fever was as fatal as with us, no new wharf, that I know of, has been filled in for years. 'Tis true, the fever first located itself and was most fatal in the lowest, most crowded, most uncleanly portions of the city; and, no doubt, the filth and crowded condition of those portions of the city aggravated the disease; but, further than this, facts will not authorize us to go. The fever extended its ravages to every part of the city, and even into the surrounding country; and in all parts, if not equally, it was terribly fatal. From that which has always been regarded the healthiest portion of the city, but partially built up as yet, where there are no wharves, and no filth has been suffered to accumulate, I have accompanied to the cemetery, from one house, two corpses, side by side, in the same hearse."

[38]The folly and vanity of present-day physicians in occasionally believing that they have discovered a new and hitherto undescribed disease is set forth in an unmistakable manner by Donaldson on pp. 25, 26 and 27 of his "Review of Medicine and Surgery," which quotation will be given below. Even as I write there come to my mind four such instances—"Brill's disease," Dukes' "fourth disease," *erythema infectiosum,* and septic sore throat. If my learned brethren who are promulgating these names, and the clinical conditions which they represent, would take the time and trouble to review the natural history of such illnesses from the earliest times to the present, they would find that the novel ideas which they entertain are wholly unwarranted. Donaldson's illuminating remarks on this phase of the subject are:

"So we learn from the records of antiquity that all febrile diseases, including all kinds of pestilences, have been known among men in all other countries under the various appellations of pestilence, plague, ardent and burning fevers, as we have already seen, by the passages of Scripture which we have quoted, even from the beginning of the Jewish nation, and that the same tremendous pestilences have raged in different periods of time, and in the same particular seasons of the year, from the earliest ages of the world. From the first settlement of the Israelites in unhealthy Egypt to the present day we have accounts of innumerable

plagues, pestilences, fevers, febrile eruptions, inflammations, fluxes, leprosies, scabs, etc., that overspread the inhabited parts of the globe and destroyed millions of the human species. And if we inspect the ancient histories of nations and countries, as well as the modern annals of medicine, we shall find that the same kinds of diseases existed in the beginning, arose from the same causes, occurred in the same seasons of the year, happen in particular situations, originated in certain states of the weather, and were marked by the same circumstances; if we review the pages of history, we shall observe them to seize persons of the same ages, sexes, conditions, constitutions and occupations, and we thence learn that all these diseases have continued through all periods of time down to the present age. And we cannot conjecture why physicians have imagined the existence of any new diseases in these latter times on any other account than because they have not been able to trace them under the same names which they have adopted, nor defined by the same characteristic symptoms which they expected to find in ancient books on medicine. But this is a preposterous supposition, the mere effect of ignorance and temerity, a vain assertion, an empty delusion: can any natural causes rise into being, or have any been created in these last times, to generate new distempers and augment the calamities of mortals? Or can the God of nature alter the common course of His providence? The Author of our beings has never thought of increasing our miseries by adding new afflictions; we may destroy ourselves, but the operations of Providence are the same forever. The reasons why no traces of these diseases supposed to be new can be distinctly found in the medical books of the ancients are the changes of their names and false translations of the original languages. Our modern reasoners forget that none of the ancients attempted to distinguish them from each other by marks, which have no difference, nor any pathognomonic signs, that would have led them to define their various characters; they are ignorant that the ancients considered all febrile diseases to bear such affinities to each other, to arise from the same identical causes, to consist of the same characteristic symptoms, and were consequently induced wisely to include all pestilential distempers in one general name—pestilence, plague, or fever—which comprehends all the epidemic diseases of modern times. The wisdom of the ancients in this particular appears conspicuously great when we consider the uselessness of all nosological distinctions and classifications of these diseases made since the days of Hippocrates; we will admire their judgments more when we contemplate the errors and confusion produced by such imagined differences; for we now hear of pestilence, called plague in Egypt, yellow fever in America, bilious, inter and remittent fever in the Indies, typhus or nervous fever in Britain; we read of the same epidemic diseases, which the ancients called red pimples, pustular apostemes, corrupting and gangrenous sores and ulcers, now called the distinct and confluent smallpox, carbuncles, etc., whereas the diseases are identically the same, having the same symptoms, are produced by the same causes, are attended with the same circumstances, require the same methods of cure in all regions of the earth where they happen to prevail, and have only obtained various names in the different languages of men, according to the idioms of those tongues, or in relation to their supposed natures, in all places under the canopy of heaven."

"I am also particularly pleased with the rules and regulations appertaining to the reporting of communicable diseases issued by the State Board of Health of Arkansas, the "Bear State." This comparatively new but aggressive board, with Dr. Runyan as president and Dr. Smith as secretary, is rapidly assuming a position in the forefront of public health bodies. Opposite conditions, however, obtained in Arkansas 75 years ago, when Frederick Gerstaecker (1816-1872), a celebrated German writer and traveler, sojourned in that State, as the following quotation from p. 86 of his famous book, "Wild Sports in the Far West," would indicate:

"I was already far enough advanced in English to be able to take part in the conversation, the educated American being very indulgent to foreigners in this respect. We sat talking together till about ten o'clock (January 27, 1838). The young wife had just received a letter from her husband, which she read through and through ten times over. She had been very unfortunate in Arkansas. The doctors had killed three of her children, and she herself was suffering from inflamed eyes through their ignorance. The fact is that there is no sufficient authority to control their practice in these new States, and every quack who chooses may call himself doctor. They prescribe calomel for every disorder, and decayed teeth, inflamed eyes, spongy gums and shattered health are the universal consequences."

On pp. 166 and 167 he writes:

"As we had had hard work for some days, I resolved on taking a holiday, and riding to the gunsmith's, about twelve miles off, to get some repairs to my rifle. When I awoke in the morning I had a dreadful headache, but I got up and mounted the horse, hoping to drive away the pain with the fresh morning air. I had hardly gone a mile when I was seized with such a giddiness that I could with difficulty keep my seat. I galloped back as fast as possible, and crept shivering under my buffalo skin, but the ague crept in with me and kept me there all that day and night. The next morning I was so much worse that I thought my last hour was approaching. I took one of the emetics I had brought with me from Cincinnati, but without effect; the fever changed from cold to hot, and increased every hour. On the nights of the 16th and 17th of September (1839) I was delirious; what I may have said I know not, as they told me that I spoke German.

"Saint could not procure a doctor. The nearest lived twenty miles off, and was seldom at home: this probably saved my life, for had I fallen into the hands

of one of these American quacks I might have prepared for my last journey. Saint happened to have some pills in the house, made by J. Sappington, and gave me one. Whether it was from the pill or my own good constitution, I was better on the 18th, and could move about the house and enjoy a little food after my four days' fast; I was very weak for a long time. I must ever memember with gratitude the kind interest with which these worthy Americans attended and nursed the poor stranger."

[40]The opinions which formerly prevailed concerning the influence of the seasons and concurrent meteorological conditions upon communicable diseases are set forth in the following paragraph, found on pp. 355 and 356 of Donaldson's "Review:"

"The summers of 1667-8-9 were excessively hot, autumns sultry and insalubrious, the winters very severe; the whole seasons were marked with tempests, storms and variable weather, which evidently produced the smallpox in Europe and America. In 1670-1-2 measles, dysenteries, smallpox, bilious colics, fevers, etc., proceeded from severe winters, sudden springs, hot summers and sultry autumns. The summer of 1676 was cold, and measles and smallpox prevailed. It would appear, then, that a sudden, warm spring and cold, wet summer, after a severe winter, will produce measles, smallpox, scarlet and malignant fevers, as happened in England and America in 1675-76-77 and 78, from the reasons which mildewed and destroyed all the fruits of the field. But I am also of an opinion that a continuance and a succession of causes are required for a series of seasons to generate an epidemic natural pox, or measles and scarlet fever, as well as the plague. The cold months of the summer and autumn of 1783 and 1784 created scarlet angina. The variable and warm weather in the December of 1788 and January and February of 1789, the cold and wet weather of April and May, constituting a cold, backward spring, produced measles. Huxham mentions a cold, damp spring in England that generated measles, which we always observed to accompany or precede the smallpox, scarlet fever, gangrenous sore thoats, erysipelas, catarrhs, etc., in our own countries. But in the tropical regions of Africa, Asia, Europe, etc., we find that natural pox prevail mortally in the cold seasons of the year, after a burning season of heat and rains. Now to prove that colds and heats, changes and peculiar constitutions of seasons generate all these eruptive distempers, I shall enquire into their real essential nature."

*(To be continued.)*

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HYGIENE OF THE NURSERY. Including the General Regimen and Feeding of Infants and Children, Massage, and Domestic Management of the Ordinary Emergencies of Early Life. By Louis Starr, M.D., LL.D. Eighth edition. With 26 illustrations. Philadelphia: P. Blakiston's Son & Co. 1913. Cloth, $1 net.

Starr's "Hygiene of the Nursery" is too well and favorably known to need the encomiums of this reviewer. As a guide to the mother and nurse it is an ideal book, being written in a clear, terse style, leaving nothing for granted, but going into the minutest detail whenever necessary. The chapter on diet will be found especially helpful to the mother. If the parent follows the direction for rearing her child as laid down by the author, she will be spared much unnecessary labor, as well as many anxious moments. We are particularly impressed that the tenor of the book, as formerly, is to emphasize hygienic methods by which the child may be kept in health, rather than the recognition and interpretation of symptoms or the treatment of disease after its onset. In our opinion, this is a very important feature, as it tends to prevent home medication, and in sickness compels the parent to send for a doctor. The nursery, clothing, exercise and amusement, sleep, bathing, food and other information necessary to the proper raising of the child are all thoroughly and in many instances in detail considered. It is a book that can safely be placed in the hands of any intelligent mother.

# Maryland Medical Journal

Nathan Winslow, M.D., *Editor.*

*Associate Editors:*

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BALTIMORE, JULY, 1913


## HYOSCINE-MORPHINE ANESTHESIA FOR ALCOHOL INJECTION IN NEURALGIA.

Realizing the difficulty of reaching the branches of the fifth nerve by needle when injecting alcohol for trifacial neuralgia without producing great pain, especially in nervous women, Wilfred Harris (*Lancet*) recommends for obtunding the pain incident to the injection one-third grain morphia and one one hundred and fiftieth grain hyoscine hypodermically into the arm 20 minutes before commencing the operation. During the lapse of this time the patient should be lying down and quiet, and encouraged to sleep if possible. That the patient is ready for the injection is indicated by his restfulness and lack of pain. It is needless to enter into a discussion of the merits of the value of alcohol in intractable tic, for it has been sufficiently well tested to have proven its efficacy. Harris has noted that after the injection of the third division of the fifth nerve at its points of emergence from the foramen ovale there is in some cases an anesthesia of the entire region supplied by the fifth nerve. He therefore reasons that the alcohol has extended to the Gasserian ganglion. Until he tried the hyoscine-morphia combination, owing to the severe pain experienced during the injection, he was compelled to resort either to nitrous oxide or chloroform anesthesia. As the masseter and external pterygoid muscles which are pierced by the needle to reach the foramen ovale should be relaxed, else considerable difficulty will be experienced in reaching the proper point, nitrous oxide alone or in combination with oxygen is not a particularly desirable anesthetic, owing to its non-relaxing property. Chloroform has the drawback of its dangerousness; besides, it necessitates the complete loss of consciousness. Therefore, in the writer's opinion, the hyoscine-morphia combination is at present the ideal

way of producing loss of sensation while injecting the roots of the fifth nerve. In injecting the third division of the fifth nerve at the foramen ovale the needle traverses the skin and the masseter and external pterygoid muscles. As the needle approaches the foramen the patient exhibits some sensitiveness, though not until the nerve is struck is a tingling sensation felt in the lower lip and tongue. When this occurs the stylet should be withdrawn from the needle and a syringe filled with 3½ per cent. eucaine solution attached and a few drops slowly injected. If there be considerable resistance to the push of the piston the point of the needle is within the nerve, and the syringe should be exchanged for another filled with 90 per cent. alcohol. After the lapse of sufficient time for the eucaine to act, usually a few minutes, two or three drops of alcohol should be slowly injected into the nerve. The patient may now feel a burning sensation in the lower lip and tongue. As soon as a few drops of alcohol have been injected into the nerve, sensation of touch becomes blunted on the lip, and slowly, two or three drops at a time, more alcohol is injected, until anesthesia is complete and a pinprick on the lip cannot be felt, not even as pressure. Usually 1½ c. c. are required to produce this effect. The second division is injected when necessary through the spheno-maxillary fossa. Here the author insists upon the use of a local anesthetic, as considerable damage may be done the ocular nerves or other important structures in the sphenoidal fissure. After the injection is completed the patient will usually sleep for two or three hours. What has been said concerning the second and third divisions applies to the supraorbital nerve.

In the hands of the writer this method has in an extended practice given rise to alarming symptoms in only one case. The disagreeable symptoms, however, soon passed off and left the patient none the worse for the experience.

Morphia, in combination with hyoscine, has for some time been used preliminary to general anesthetics, and in some instances when chloroform, ether or nitrous oxide were contraindicated as a general anesthetic. Such operations as removal of the breast, kidney, etc., have been done under its influence, but, with a wider familiarity with its effects, the users came to the conclusion that it was not the harmless agent supposed. However, in tic and when used as advised by the author, namely, one injection 20 minutes before the operation, it should prove a beneficent agent in controlling the pain incident to the procedure.

# Medical Items.

The annual commencement of Johns Hopkins University was held at 4 P. M. Tuesday, June 10, 1913, at the Academy of Music. Dr. Albert Shaw, editor of the *Review of Reviews* and a Hopkins alumnus, made the address to the graduates.

An appeal for a surgeon to accompany the Crocker land expedition, which is to sail from New York on July 2 for an excursion into the Arctic regions, with Smith Sound as the objective point, has been sent to Dr. William H. Howell, professor of physiology, Johns Hopkins Medical School. The expedition is for the purpose of scientific work.

The honorary degree of Master of Arts was conferred on Dr. Nathan Winslow at the commencement exercises of St. John's College, June 18, 1913.

Through Governor Goldsborough, announcement has been made that Mrs. Alfred I. du Pont, wife of the Wilmington multi-millionaire, will donate a maternity hospital, which will be erected in connection with the general hospital at Cambridge, Md., and will be known as the du Pont Maternity Hospital. The hospital building has been designed by Parker, Thomas & Rice of Baltimore and Boston, the erection of which will begin immediately.

The Johns Hopkins Summer School opened June 2, with 51 students. The course will last six weeks, and special courses will be given for graduates. The teachers are Drs. John M. T. Finney, J. C. Bloodgood, Guy L. Hunner, J. P. Pratt, L. V. Hamman, C. G. Guthrie, C. G. Snyder, E. K. Marshall and L. G. Towntree.

Dr. Joseph Clement Clark, Sykesville, has been re-elected superintendent of the Springfield State Hospital.

Dr. W. J. Riddick, University of Maryland, class of 1905, Assistant Surgeon, U. S. Navy, formerly of Washington, D. C., has been transferred from the U. S. S. Wheeling to Marine Expeditionary Force.

Dr. H. E. Jenkins, University of Maryland, class of 1905, Assistant Surgeon, U. S. Navy, formerly of Washington, D. C., has been transferred from the U. S. S. Nashville to Marine Expeditionary Force.

At the 166th commencement exercises of Princeton University, June 11, 1913, the degree of Doctor of Science was conferred on Dr. Simon Flexner, organizer and now director of the Rockefeller Institute, and a former Johns Hopkins man.

Dr. James D. Iglehart of West Lanvale street is visiting friends in Chicago.

Among those who have engaged passage on the Lapland, which will sail July 26 for Europe, are Drs. Hampton Young, Lewellys Barker and Harvey Cushing.

Dr. William S. Thayer, professor of clinical medicine, Johns Hopkins University, was one of the speakers at the commencement exercises of the Gilman Country School, Roland Park, June 10, 1913.

Dr. Eugene N. Jones, Baltimore Medical College, class of 1896, of Kensington, Montgomery county, has announced his candidacy for the State Senate, to succeed Senator Blair Lee.

At the commencement exercises of Dickinson College, the honorary degree of Doctor of Science was conferred on Dr. Guy L. Hunner, professor of surgery at Johns Hopkins University.

A son—Roscoe Drake, Jr.— was born June 11, 1913, to Dr. Roscoe Drake McMillan, University of Maryland, 1910, of Red Springs, N. C., and Mrs. McMillan.

The committee on fractures of the American Surgical Association desires to have two reprints of any paper dealing with the non-operative or operative treatment of *open or compound fractures* which have been published within the last five years.

The committee also desires papers on the *medico-legal relations of radiography* to the diagnosis and treatment of fractures.

If authors on these subjects have no reprints, the committee would be pleased to receive memoranda of the places of publication of such papers.

John B. Roberts,
Chairman Committee on Fractures.
313 S. 17th Street, Philadelphia.

Dr. Carville V. Mace, University of Maryland, '97, who recently underwent an operation for stone in the kidney, is convalescing.

The Phipps Psychiatric Clinic of Johns Hopkins Hospital opened for the reception of patients on May 1.

The engagement is announced of Miss Eleanor J. Cary of this city to Dr. Francis R. Crawford, Johns Hopkins Medical School, '11. The marriage will take place in September, and after the wedding trip, spent in Europe, Dr.

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Crawford and his bride will leave for China, where they will both devote their lives to missionary work.

Dr. L. McLane Tiffany and Mrs. Tiffany have closed their house, 831 Park avenue, and opened their home in Virginia for two months.

Ground will be broken very soon for an emergency hospital at Easton to be constructed of reinforced concrete, brick and stone, with a central building and wings.

Plans have been prepared for a new building for the treatment of tuberculous patients at the Springfield State Hospital, Sykesville. It is to be two and one-half stories in height, 67x 97 feet, and of brick and concrete construction.

Dr. Fannie E. Hoopes has returned from a trip around the world.

The commencement exercises of the Nurses' Training School of the Maryland Tuberculosis Sanatorium, of which Dr. Victor F. Cullen, a former Johns Hopkins student, is superintendent, were held on May 14. There were four graduates—Misses Mabel G. Flory, Hagerstown, Md.; M. Eleanor O'Connor, Baltimore; Rebecca Silverman, Baltimore, and Emma A. Strumsky, Baltimore.

Dr. William H. Welch, professor of pathology at Johns Hopkins, attended scientific conferences in New York and Boston.

Dr. Winford H. Smith, superintendent of Johns Hopkins Hospital, recently made a trip to New York to show the plans for the new James Buchannan Brady urological clinic to the donor of the clinic, Mr. Brady, which were approved. This clinic was made possible by a gift of $200,000 from Mr. Brady. The building is to be of brick, five stories high, and to adjoin the present surgical building. Mr. Brady will give $15,000 annually for maintenance and support.

Among the Johns Hopkins alumni located in China is Dr. Francis J. Hall, who occupies a teacher's position in the Pekin College. Dr. Hall is at present engaged in editing the second Chinese edition of Dr. Osler's textbook on the practice of medicine.

Dr. Louise Pearce has been appointed first assistant to Dr. Adolph Meyer, director of the Phipps Psychiatric Clinic.

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**MARRIAGES.**

Henry Theodore Collenburg, M.D., Johns Hopkins Medical School, '10, of Baltimore, to Miss Mary Neale Stewart of Walbrook, Md., at Walbrook, June 14, 1913. Dr. and Mrs. Collenburg will reside at 3103 Clifton avenue, Walbrook.

George S. Everhart, M.D., University of Maryland, '97, of Hanover, Pa., to Miss Edith Phreaner of Hagerstown, Md., at Baltimore, June 4, 1913.

Rupert Norton, M.D., Harvard Medical School, '93, assistant superintendent of Johns Hopkins Hospital, of Baltimore, to Miss Cecelia Hendrickson of Frederick, Md., at Brooklyn, N. Y., June 7, 1913. After an extended wedding trip Dr. and Mrs. Norton will occupy an apartment in Earl Court.

Frederick H. Vinup, M.D., University of Maryland, '09, of 1221 Hollins street, a city health warden, to Miss Marie Belle Murchison of LaGrange, N. C., at Westminster, Md., June 12, 1913. Dr. and Mrs. Vinup will reside at 7 N. Carey street, this city.

Raymond Bartlett Morris, M.D., Johns Hopkins Medical School, '10, of Olean, N. Y., to Miss Mary L. Parrish of Baltimore, May 14, 1913.

Franklin Edgerton, M.D., late of Johns Hopkins University, of Washington, D. C., to Miss Mary E. Eagan of Washington, at Washington, June 5, 1913. After a short wedding trip Dr. and Mrs. Edgerton will reside at 2852 Ontario road, Washington.

Frederick De Sales Chappelear, M.D., University of Maryland, '04, of Hughesville, Md., to Miss Katharine P. Hughes of Washington, D. C., at the Cardinal's residence, Baltimore, June 3, 1913.

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**DEATHS.**

Eugene Lee Crutchfield, M.D., University of Maryland, '87, fellow-member with President Woodrow Wilson of the Johns Hopkins Glee Club, died at his home, 1221 E. Preston street, of pneumonia, June 12, 1913, aged 50 years.

Conrad P. Strauss, M.D., College of Physicians and Surgeons, '87, died at his home, 1606 Light street, Baltimore, May 2, 1913, aged 50 years.

Benjamin F. Shipley, M.D., University of Maryland, '83, of Ellicott City, Md., died at his home, near Alpha, June 13, 1913, aged 69 years.

Francis Jencks Hall, M.D., Johns Hopkins Medical School, died of typhus fever at Peking, China, where he was dean of the Union Medical College, May 25, 1913.

MARYLAND
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## THE WORK OF THE HEALTH DEPARTMENT OF BALTIMORE CITY.*

*By Nathan R. Gorter, M.D.,*
Commissioner of Health.

I have accepted the invitation to address your association on the subject "The Work of the Health Department" because of my desire to do all that is within my power to show appreciation of the interest of the public in civic affairs and especially the interest of the Women's Civic League in the Health Department.

Had I the privilege I would confine my attention to those portions of the work which have been attracting the attention of the people during the past ten years; but probably after all it will be better to rapidly review all of the work, with special attention to some few of its divisions, rather than at this time attempt a dissertation on any one portion of the work.

The watchword of Health Departments of today is "Prevention." While this watchword perhaps presents nothing new or startling to you, yet in reality prevention work is comparatively recent in the history of Health Departments, certainly in the accomplishment if not in the idea. Before presenting to you the present-day work of the Sub-Department it will be of some interest to you to recall for a moment some facts which will illustrate that prevention has become the predominant idea in health work. When Baltimore became a chartered city in 1797 the Health Board was constituted, and from that time up to 1875 it seems to have been a receptacle of complaints and an advisor in times of epidemics.

The broad foundation of our present activities was begun in 1875, when an ordinance was passed requiring a burial permit to be issued by the Department for the interment of dead bodies. This was the beginning of our Vital Statistics record, which was preceded by records of superintendents of cemeteries and of the sextons of churches. Another important ordinance was passed in 1884, which required the recording of all births. This ordinance, like many that have been passed from time to time, was

*Paper read May 6, 1913, before the Women's Civic League.

obtained by a few people who were thinking and acting alone; who were far beyond the times and so far beyond the intelligent interest of the public that the observance was more in the breach than in the compliance, until the past year saw the enactment of another law which is rapidly producing its desired effect on the birth registration.

The foundation was made broader also in 1882, when, because of another awful visitation by smallpox, very drastic ordinances were passed concerning the notification of the Health Department of infectious diseases, especially smallpox, which in 1890 were made to include the so-called minor diseases, such as scarlet fever and diphtheria. The ordinance of 1882 also included the putting into the hands of the Commissioner of Health "compulsory vaccination" against smallpox, which marked the first step towards the active prevention of disease. The effectiveness of this measure is shown in the absence of epidemics of smallpox for thirty years, while formerly they recurred in about every ten years. The effectiveness is also shown in the futile efforts of smallpox to become epidemic in 1892-93, 1899-1900, 1905-06, and 1912-13. This disease never can become epidemic so long as the people are truly vaccinated and the Commissioner of Health retains his power to compel vaccination.

The decade 1881-1890 saw the wonderful development in our knowledge of the causes of communicable diseases. Since then this knowledge has from time to time been extended to more and more of these diseases, until now we believe that all communicable diseases are caused by living things or germs which are for the most part demonstrable by the microscope. This gave the idea of a new development in department activities which resulted in the establishing of the Bacteriological and Chemical Laboratories, which afford facilities for all physicians to diagnose early cases of tuberculosis, typhoid fever and diphtheria, and to detect sources of disease, such as typhoid fever, as might be evidenced by the chemical reactions of the drinking water. These laboratories have been active and growing since their creation, and today show their value to the community by their varied and extensive work.

Long before the great and valuable work by the public in the interest of Preventive Medicine, which was probably first evidenced against tuberculosis, the Health Department endeavored to obtain the passage of an ordinance requiring the registration of cases of tuberculosis. Such an ordinance was passed in May, 1896, and exists today in its emasculated form as a monument to the efforts of a few in the right direction and a demonstration of the successful opposition on the part of the people and many physicians.

The last quarter of the nineteenth century witnessed not only a revolution in medicine as to the cause of disease, but also witnessed the spread of knowledge of disease amongst the laity

which has strengthened to a wonderful degree the hands of health officers and also made possible the development of new activities which make for a broader scope of Health Department work and the raising of the average of resistance to the advance of disease.

One of the first results of this new activity was the creation of the division of Public School Inspection. The ladies of the Arundel Club, through one of its committees, studied thoroughly the situation, and after several months of work succeeded in getting the School Board to request the Commissioner of Health, in the year 1905, to institute School Inspection. Accordingly, the Commissioner, with a committee of ladies, waited on the Board of Estimates and obtained an immediate appropriation from the contingent fund of sufficient money to commence the work with two physicians and three nurses, and received the promise that the next ordinance of estimates should contain appropriation for five physicians and five nurses. This promise was fulfilled, and work has continued, until now, being done as satisfactorily as such a small force could do it. It has been apparent to many that this work should have progressed by an increase, especially in the force of nurses, organized under a special head or Division, which would probably bring about not only definite constructive work as to the health of the school children, but also a development in the teaching of the knowledge of hygiene, both practical and theoretical, which would ensure the instruction of the men and women of tomorrow in those facts which when put into practice by them would tend towards the elimination and prevention of disease. This must be a part of the work of the future or else the successful fight against tuberculosis, infant mortality, etc., will be much more difficult and prolonged.

The second activity of special note is found in the work of the Maryland Tuberculosis Association and the Visiting Nurses' Association, which for several years maintained the services of nurses to visit and instruct the tuberculous sick. In the year 1909, because of the ever-increasing burden on private philanthropy and because it was clearly the duty of the entire city to do the work that, directly or indirectly, concerned every family, the Tuberculosis Association and the Commissioner of Health presented the facts to the Board of Estimates, who immediately responded by providing funds for two nurses and promised to provide for fifteen nurses in the next ordinance of estimates. This was done, and the force has remained the same until now, except the very important additions of two nurses and one physician for the management of tuberculosis dispensaries, that now amount to three in all.

The last activity to which I shall refer is that concerned in the improvement of our milk supply with special reference to Infant Mortality. I am not sure whether all of you are acquainted with the fact or not that one of the five active "outside" influences to assist the Department in this line was a committee or organization of milk distributors, who waited on the Commissioner of

Health in 1908, asking that better and more effective milk laws be passed. This committee of milkmen and a representative of the Department of Health wrestled with the problem, and the result of their work was presented to the City Council. It was then the great power of educated and aroused laymen was manifested. The demonstration that was then made surprised more than one in many walks of life, and resulted in the passage of the ordinance in its entirety. The immediate result was an increase of inspectors of milk, with some improvement in the milk supply. Unfortunately the improvement was not continuous, and it was not long before the supporting public demanded greater results, which were evidenced especially by the activities of your organization. These demands have resulted first in permanently establishing and increasing the force of dairy farm inspectors in 1913, who have already given evidence of their value by the results of their work; and, second, the declaring by the Commissioner of Health of bacteriological standards for milk—raw and pasteurized.

That which I have said thus far may be considered by some, if not all of you, as not entirely appropriate in an address on "The Work of the Health Department," yet my plea for thus taking so much of your time is that something of the kind is necessary to emphasize the fact that the recent change and development of our work has been and must continue to be actively assisted by the intelligent co-operation of the public.

We will now direct our attention to our Department as it is. For many years it has been evident that the work would be greater and better done if the workers were divided in divisions or bureaus, having at the head of each one of them trained men who could devote their whole time to their duties. While this has not yet been accomplished, there has been a sufficient natural separation which enables me to refer you to twelve divisions:

1. Maritime Quarantine.
2. Sydenham Hospital.
3. School Inspection.
4. Vital Statistics.
5. Plumbing.
6. Tuberculosis Work.
7. Health Wardens.
8. Communicable Diseases.
9. Disinfection and City Burials.
10. Tenement House Inspection.
11. Food and Dairy Inspection.
12. Laboratories.

You can rest assured that I would not have thought of wearying you by entering into a detailed account of work of these divisions even if I had commenced this address with the first on the list, much less therefore do I contemplate now such a thought, but I presume you may desire something concerning each one.

*Maritime Quarantine:*

Although this division work is not commonly considered as part of our work, yet it forms a very important part of our duties. The close relationship of the work of this division to the general work of the Department was especially emphasized by those who drew up the charter which became effective in the year 1900, who definitely placed the Commissioners of Health at its head and designated the Quarantine Physician as one of the Assistant Commissioners of Health of the city. The station is located in Anne Arundel County, opposite Fort Carroll. A force of eighteen men and women are employed, with the Quarantine Officer and his assistant in command. Their duties are, first, to guard the port from invasion by disease which might be brought by vessels, and, second, to care for the sick suffering with the so-called major diseases, smallpox, yellow fever, etc., that might develop within the city. During the year 1912 the following work was done:

| | | |
|---|---|---|
| Steamships examined | 592 | |
| Sailing vessels | 23 | |
| | | 615 |
| People examined: | | |
| Crews | 23,414 | |
| Passengers | 30,142 | |
| | | 53,556 |
| Money received for: | | |
| Inspection of vessels | | $13,136.56 |
| Care of patients and fumigation of vessels | | 1,574.00 |
| Total receipts | | $14,710.56 |

The city appropriation for expenses and salaries was $20,875. This leaves as a total cost to the city of $6,154.44. This is offset by the care of smallpox cases, which last year we commenced to send to Quarantine on November 11th and continued until March 1st, 1913, during which time 57 cases of smallpox and 174 "contacts" were cared for.

*Sydenham Hospital* is our hospital for the so-called minor infectious diseases, scarlet fever, diphtheria, measles and chickenpox. The effort to establish such a hospital commenced, I understand, about 1879. Just as in many other cities, there was the usual opposition of blind ignorance and selfishness which successfully fought such a hospital until the year 1909. Indeed, for a time the fight was practically given up until a proposition was made for the Board of Supervisors of City Charities and the Health Department to combine forces in an effort to obtain the Hardesty estate. After this was accomplished, twenty acres of that estate was set aside for the purpose of erecting thereon the hospital, which was subsequently named "Sydenham." Including the Superintendent, there are eighteen people employed regularly in

this work. At times there is an increase in the force of nurses, as occasion may require. Only white people are cared for and only those suffering with scarlet fever and diphtheria. During the year 1912 there were 181 admissions. Of these 102 were scarlet fever and 79 diphtheria. Many others, however, were refused admission because the utmost capacity is only 56.

*School Inspection:*

Employed in this work we have five physicians and five nurses. At the beginning of this work every child in the Public Schools up to and including the eighth grade was regularly inspected. Experience soon demonstrated, however, that it was practically of no value to continue the examination except the defectives beyond the fourth grade, so the regular examinations are of the first four grades, after which we follow only those already found defective. This restriction became all the more imperative when we were requested to take over the thirty-eight Catholic parochial schools, which included twenty thousand children. In the year 1911 there were 35,988 children examined, and 19,554 were found defective. The number of these defective that were treated, relieved and cured was exceedingly large, but the number in the year 1911 could not be tabulated. It is in the "follow-up" care by the nurse that the most effective work is done, and, as I will mention later, it should be made greater by increase in the number of nurses.

*Vital Statistics:*

In the sense that this is the basic work for future activities, we should probably have considered this first amongst the divisions of the Department. Anything approaching a description of the detail of this work is impossible at this time. At present there are five employes engaged in issuing permits for burial, indexing births and burials and tabulating the cause of death, with occasional assistance of two others. Last year (1912) there were 10,441 deaths and 11,398 births recorded and tabulated. It is probably not generally known that every death occurring in Baltimore is transcribed and sent to Washington.

*Plumbing Division:*

The work of this division is exceedingly large and severely taxing. There are twenty-three men employed—one chief, seven clerks, fifteen inspectors. The work is admirably systematized, and on the files may be found plans for plumbing of new buildings, sketches of changes in old plumbing and the plans of house connections with the new sanitary sewers, besides the records of sanitary inspections. Permits must be issued for all this work and a careful watch kept of the execution of the same by plumbers. During the year 1912 the following appears on the records:

PERMITS ISSUED.

| *Interior Plumbing.* | *Alley Permits.* | *Connecting With Private Sewers.* | *Total.* |
|---|---|---|---|
| 2,541 | 439 | 12,883 | 15,863 |

Total number of plumbing inspections..... 29,743
Total number of sanitary and drain inspections.. 12,656

CITY SANITARY SEWERS.

Total permits to connect up houses..... 14,291
Permits in addition to the above issued..... 4,252

*Tuberculosis Division:*

In this division are employed one nurse-in-chief, who is in charge of the work; one physician and sixteen nurses. Fourteen of the nurses are doing "field" work, which means the visiting of patients (with the consent of physicians), giving them and their families instructions in prophylaxis and feeding, and frequently giving personal care of the patient's body. At this time they have in charge 3,232 patients. They are active in looking up suspected cases and obtaining diagnoses of them either by private physicians or by the physicians at dispensaries; also in obtaining admission to sanatoria or to the Municipal Hospital at Bay View. They also distribute prophylactic supplies given by the State. The physician and the other two nurses are engaged in the work at the municipal dispensaries (tuberculosis), two of which were established last year and one this year. Two afternoons are given to each of the dispensaries each week, and the attendants are engaged in the examination and treatment of cases, obtaining care at sanatoria, or having the home work looked after by the field nurses. A very great deal of work is constantly going on which is a severe tax on the physical endurance of all.

*Health Wardens:*

There are twenty-four physicians who are health wardens, each for his own ward. Acting in this capacity, they inspect all complaints of nuisances, in which they are frequently assisted by the Plumbing Division. All nuisances are recorded in ward books by a "complaint" clerk, who keeps also a record of what is done in each instance by the warden and keeps the account of each complaint open until the health warden returns a stub marked "Abated." All notices to abate nuisances reported by the police are sent out by the health wardens, and they conduct all prosecutions for the non-abatement of nuisances. They also placard houses when scarlet fever and diphtheria exist and instruct the family concerning regulations governing each case, and each house placarded by them is under their surveillance, which sometimes requires prosecutions for non-compliance with orders. In addition to the above, they are required to vaccinate all citizens who apply at their office and to vaccinate all school children reported

by school examiners and keep a record of the same. Certificates are issued by them for children to return to school in special cases referred to them by truant officers. They are put on special vaccination house-to-house work at times of threatened outbreak of smallpox, prosecute midwives for non-report of infants' sore eyes, and send a postal card to the teachers in public schools for every case of scarlet fever, diphtheria and measles.

*Communicable Diseases:*

This division has not yet been fully developed, but I can state that there are now two men engaged in the special work:

1. Recording and indexing by streets of infectious diseases.
2. "Spotting" maps of the city showing location of cases of disease and deaths from the same.
3. Keeping individual records of reports by physicians of infectious diseases and births.
4. Keeping a record of midwives, their reports of births and sore eyes of infants.
5. Preparing and sending semi-weekly reports (2,000 plus) of sick children to public schools.

*Disinfection and City Burials:*

Rooms are disinfected for cases of scarlet fever, diphtheria and tuberculosis, and upon request for many other diseases, such as cancer. One man is in charge of five fumigators, two funeral wagon drivers, two drivers of wagons for goods to be fumigated and one morgue keeper. He keeps a careful record of work done by the men under him, which enables us at all times to supply the record of any house previously infected. At the Morgue, in the post-mortem room, examinations of bodies are made by the medical examiner and assistant when required to do so by the coroners or by the Department. At the approach of warmer weather, as the infectious diseases lessen, the fumigators are directed to the oiling of ponds, etc., to lessen mosquito breeding. The record last year shows:

| | |
|---|---|
| Rooms fumigated | 18,024 |
| Bodies buried by city | 842 |
| Bodies handled at Morgue | 379 |
| Goods incinerated, pieces | 1,346 |
| Goods sterilized, pieces | 1,916 |

*Tenement House Division:*

This division has not progressed very far in the study of the housing question in Baltimore. It has, however, accomplished the recording and indexing of 2,457 tenement and lodging houses. The report for the past year shows as follows:

| | |
|---|---|
| Number of houses inspected | 3,122 |
| Reinspections made | 4,226 |
| Nuisances abated | 2,427 |

This division has the service of one chief and two assistants.

*Food and Dairy Division:*

In this division there are seventeen inspectors, who are placed under the chief of the Chemical Laboratory. Of these seventeen inspectors twelve are in the milk sub-division. One of these twelve we had coached by Washington and Rochester authorities before undertaking his work here, and lately he has been in charge of the inspectors in the field. I have already recited to you some of the improvements in this division, both in personnel and in results of work. The enforcement of the Eisenbrandt law has reduced the cow stables (private and dairy) from three hundred and ninety-four to forty, and these are in the outer portions of the city. Under one of the dairy inspectors the city and Highlandtown dairies were placed for some years, and this class of milk producers is peculiar unto itself, being made up mainly of a foreign element that is somewhat intractable. They have now, I understand, been brought to a much higher plane than they formerly occupied, and seemingly have accepted with only a passing protest our last order that milk from swill and garbage fed cows shall not be sold in this city after July 1st. In this I may be mistaken, because it has been asserted that several thousand dollars had been raised as a contingent fund to fight the order in court. We hope, however, that our belief that they have accepted the situation is correct, but if it is not, we are quite ready for a contest in court. The dairy inspection in what we might call the railroad milk districts was begun in the early part of this past March, and already the inspectors have demonstrated their value. It is of special interest to note that the chemical and bacteriological examinations of milk have shown conditions of the milk that caused the sending of an inspector at once to the farm where the milk was produced, and they there found conditions that not only caused the shutting out of the milk from this market, but also in some instances the removal and destruction of some of the cows because of the presence of tuberculosis. Such work must soon tell markedly in the character of the milk, because one obtains not only the immediate results on these farms, but also the news of the work being done by the Department will bring about changes for good in other farms. This dairy farm inspection will in the end prove the greatest and most lasting benefit in the improvement of milk. We are pleased to note that there has been an increase in the number of milk distributers who are pasteurizing the milk and that there is now pasteurized forty-one per cent. of the milk sold. We have learned that in all probability even a greater percentage will be pasteurized as soon as the methods of commercial pasteurization of milk are perfected. We believe in keeping of the milk free from contamination as of first importance, but we also believe that proper pasteurization is an additional safeguard, more especially as pasteurization requires still another safeguard, i. e., the sale of milk in bottles or similar containers. We are, therefore, endeavoring to bring about:

First—Greater protection of milk at the farm.
Second—Pasteurization of milk as an additional safeguard.
Third—The dispensing of milk in original packages.

The report for 1912 shows as follows:

| | |
|---|---|
| Laboratory milk examinations (chemical) | 27,871 |
| Amount of milk received at railroad stations, gallons | 8,862,878 |
| Amount of milk examined at railroad stations, gallons | 714,972 |
| Amount of milk condemned at railroad stations, gals. | 9,085½ |
| Number of city dairy inspections, including milk shops | 14,082 |
| Number of milk wagon inspections | 5,243 |
| Total number of nearby dairy farms | 110 |
| Visits to nearby dairy farms | 1,684 |
| Visits to railroad farm dairies (including reinspection by one inspector | 550 |
| Number of farms visited (including 5 creameries) | 343 |
| Number of revocations of milk permits | 101 |
| Number of prosecutions | 13 |
| Laboratory examinations (bacteriological) | 5,031 |
| Pasteurized milk sediment (bacteriological) | 63 |
| Microscopic examinations for pus and streptococci | 1,652 |

Besides the milk inspectors, the other food inspectors, four in number, are concerned:

First—One inspector at the abattoir.
Second—Two inspectors at the market and at stores for meats and vegetables.
Third—One inspector of bakeries.

This work has been summarized for 1912 as follows:

| | |
|---|---|
| Number of store inspections | 13,002 |
| Number of visits to markets | 2,067 |
| Number of visits to wharves | 8,325 |
| Number of visits to abattoirs | 586 |
| Number of visits to slaughter houses | 3,383 |
| Number of visits to bakeries | 3,217 |
| Total amount of foodstuffs condemned (exclusive of milk and animals on hoof), pounds | 3,288,932 |
| Total number of carcasses condemned | 420 |

*Laboratories:*

Our two laboratories have the following equipment of workers:

Bacteriological Laboratory:
- One chief bacteriologist.
- Four assistant bacteriologists.
- One special laboratory assistant.
- Three general laboratory assistants.
- One laboratory inspector.
- One laboratory clerk.

Chemical Laboratory:
- One chief chemist.
- Two assistants.
- One clerk.
- One assistant clerk and stenographer.

A special work was undertaken last year, i. e., the preparation and distribution of anti-typhoid vaccine. This is in the hands of one of the assistant bacteriologists, who also attends to some of the other general work of the laboratory. This vaccine has been used in institutions and military organizations of the city, also by many physicians, to immunize the families of their poor patients where cases of typhoid fever had occurred.

For the accommodation of physicians the Department has one man to maintain supplies at 129 stations and 65 sub-stations. The 129 stations are drug stores that are regularly visited about every two weeks, and the sub-stations are drug stores whose proprietors send to the Department for supplies. This work in 1912 was as follows:

| | |
|---|---|
| Number of culture tubes prepared and distributed | 20,800 |
| Number of culture tubes brought back | 11,476 |
| Number of culture tubes used and sent to the Department | 5,845 |
| Number of typhoid boxes prepared and distributed | 3,020 |
| Number of typhoid boxes used and sent to the Department | 2,217 |
| Number of miscellaneous outfits prepared and distributed | 94 |
| Number of miscellaneous outfits used and sent to the Department | 82 |
| Number of sputum outfits prepared and distributed | 3,481 |
| Number of sputum outfits used and sent to the Department | 2,318 |
| Number of combined blood, urine and feces culture outfits distributed | 121 |
| Number of combined blood, urine and feces cultures used and sent to the Department | 85 |

Another special employe connected with the laboratories is he who is the "official" sample collector. This work in 1912 is tabulated as follows:

| | *No. of Specimens.* |
|---|---|
| Water, city | 760 |
| Water, lake | 336 |
| Water, table | 39 |
| Water, pump | 12 |
| Water, spring | 40 |
| Water, filtered | 5 |
| Water, harbor | 15 |
| Milk, before pasteurization | 205 |
| Milk, after pasteurization | 205 |

The work of the two laboratories, in addition to the milk work, during 1912 is tabulated as follows:

| | |
|---|---|
| Diphtheria cultures examined | 2,603 |
| Cultures examined by throat inspectors | 4,010 |
| Specimens of sputum | 2,318 |
| Blood examined for typhoid | 2,217 |
| Blood examined for para-typhoid | 128 |

| | |
|---|---|
| Typhoid bacillus from blood cultures | 87 |
| Blood examined for malaria | 513 |
| Specimens from institutions and hospitals examined for diphtheria | 1,265 |
| Specimens examined for meningitis | 22 |
| Diphtheria antitoxin supplied—units | 5,654,000 |
| Persons who received anti-typhoid vaccine | 835 |
| Injections of anti-typhoid vaccine | 2,505 |
| Miscellaneous examinations | 159 |
| Water examinations (bacteriological) | 1,390 |
| Bacteriological examination of oysters | 3 |
| Bacteriological examination of ice | 5 |
| Bacteriological examination of ice cream | 120 |
| Bacteriological examination of harbor water | 173 |
| Bacteriological examination of rats (bubonic plague) | 145 |
| Chemical examination of water | 309 |
| Chemical examination, miscellaneous | 925 |

Number of health officers and employes and cost:

In all there are 182 on the pay-roll.
Eighteen of these are at Quarantine.
Eighteen of these are at Sydenham.

The total appropriation for the Health Department in 1913 was $213,415. This makes the per capita cost to the citizens of Baltimore 37c. per annum. I have mentioned this not for the purpose of making comparisons with other cities (because this is not yet possible for the want of a uniform method of accounting for Health Department expenses), nor to compare the amount of money obtained by the Health Department with that received by other departments, but merely to let you know what the actual cost is and to plead that the work that is being done by the Health Department is not only worth that which is represented by the 37c. per capita, but also that with an additional expenditure by the Department there would be probably ever greater returns in good health and lessened death rate, which cannot be reckoned in dollars and cents.

Now, what of the future? I can truthfully say that every one of the twelve sections that I have referred to might be improved with great profit to the city, but as such a thing is now not to be thought of I have concentrated my thought on a few of the divisions already in operation and one that should be added:

1. Sydenham Hospital should be increased in capacity so that it might prove to be a real benefit to the city in lessening the number of infectious diseases.

2. The school inspection ought to have its force increased, especially in the number of nurses, and there should be not less than ten, or preferably fifteen.

3. Vital statistics should have specially trained men for the work and the force increased to a size sufficient to obtain all the good that is contained in the records of deaths and births.

4. The tuberculosis work ought to be permitted to steadily develop both in point of numbers engaged in the work and in the character of the work. Two hundred to 250 cases in charge of each nurse is entirely too much, and the maximum good is far from being accomplished, but in addition to this we must have a segregation hospital for the care of the advanced cases of tuberculosis which are burdens to their families and are dangerous as foci of distribution of the disease. The removal of such cases will permit not only the families to be freer from possible infection, but will enable them to do better and more work so that more money may be obtained for the purchase of better and more food and thus develop or maintain their own resisting power.

5. As far as the food and dairy inspection is concerned, the thing that is necessary is an increase in force. Anyone who knows what bacteriological and chemical examinations mean can fully appreciate from our reports, and more especially by an examination into the actual working of the Department, that our present force is worked to its limit, and therefore more work is only possible with an increase of force. This applies not only to inspectors, but also to the chemists and bacteriologists.

6. Infant mortality is closely affiliated with the improvement of the milk supply, but there is a great deal more to be accomplished along other lines in order to obtain the minimum death rate of infants under one year, and this consists to a great extent in the direct instruction of the people who have the care of infants, and I believe that this can be best obtained by a corps of competent and willing nurses of more than one nationality so that we might have nurses who could appeal to the mothers in their native language. I think if you will study carefully the deaths of children you will find that a large number of them will not be prevented through the improvement in the milk supply alone. In all these things we confidently look for the sympathy and co-operation of the public.

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# ON THE REPORTING OF COMMUNICABLE DISEASES.

*By C. W. G. Rohrer, M.D.,*
Maryland State Department of Health.

*(Continued from July Number.)*

## VI. Status of the Counties of Maryland.

The infectious disease returns from the counties of Maryland may be classified as "very good," "good," "bad" and "very bad." In every instance I shall give a table showing the status of the county discussed to confirm my opinion in the matter. The mere fact that we are now getting in from 6000 to 8000 reports[41] of con-

tagious diseases would indicate that a majority of the counties can be classed as "good."

I shall also give the area in square miles and the population of each county, together with the health officer or officers, so that the contagious disease returns can be judged by the standard of population and not by figures alone.

The total area of the State of Maryland is 12,210 square miles, of which the land surface constitutes 9941 and the water surface 2269 square miles.[42] The population of the State in 1910 was 1,295,346; of this number 558,485 persons were residents of Baltimore, leaving rural Maryland (the entire State of Maryland, exclusive of Baltimore city) with a population of 736,861.

### Allegany County.

Area in square miles, 440.5.

Population, 62,411.

Dr. J. C. Holdsworth, County Health Officer.
Dr. Francis E. Harrington, Health Officer of Cumberland.
Dr. Timothy Griffith, Health Officer of Frostburg.
Dr. James O. Bullock, Health Officer of Lonaconing.
Dr. A. B. Kalbaugh, Health Officer of Westernport.
Dr. F. H. Charles, Health Officer of Midland.

Alphabetically arranged, Allegany heads the list of the 23 counties in Maryland; it also stands first in the reporting of communicable diseases, as the following table will show. The "very good" returns from this county, totaling 1567 for the year 1912, are largely the fruits of the untiring labors of Drs. Harrington and Holdsworth, who have done so much for their respective jurisdictions.

COMMUNICABLE DISEASE CASES REPORTED IN ALLEGANY COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | 25 | 13 | 12 | 18 | 13 | 22 | 13 | 45 | 34 | 68 | 44 | 22 | 329 |
| Scarlet fever | 2 | 3 | 5 | .. | 1 | 1 | 3 | 2 | 6 | 9 | 6 | 2 | 40 |
| Diphtheria | 13 | 6 | 3 | 1 | 1 | 2 | 2 | 11 | 3 | 13 | 8 | 4 | 67 |
| Whooping cough | .. | .. | 3 | 1 | 2 | 2 | 2 | 1 | .. | 1 | 3 | .. | 15 |
| Measles | .. | 2 | 26 | 185 | 181 | 94 | 78 | 24 | 1 | 4 | 75 | 343 | 1013 |
| Chicken-pox | 4 | 11 | 20 | 2 | .. | .. | .. | .. | 1 | 1 | 5 | 14 | 58 |
| Mumps | 2 | 5 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 7 |
| Influenza | 1 | .. | .. | .. | .. | .. | .. | 2 | .. | .. | .. | .. | 3 |
| German measles | .. | .. | .. | 2 | 2 | .. | .. | .. | .. | .. | .. | .. | 4 |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 11 | 9 | 20 |
| Malaria | .. | .. | .. | .. | 1 | .. | .. | .. | .. | 1 | .. | .. | 2 |
| Meningitis | 1 | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | 2 |
| Erysipelas | 1 | .. | .. | 1 | .. | .. | .. | .. | .. | 1 | .. | .. | 3 |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | 1 | 2 |
| Septicemia | .. | 2 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 2 |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Pellagra | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | 49 | 42 | 69 | 210 | 201 | 121 | 98 | 86 | 45 | 98 | 153 | 395 | 1567 |

## ANNE ARUNDEL COUNTY.

Area in square miles, 430.4.

Population, 39,553.

Dr. Walton H. Hopkins, County Health Officer.
Dr. Wm. S. Welch, Health Officer of Annapolis.
Dr. Charles H. Brooke, Health Officer of First Precinct.
Dr. Thomas B. Horton, Health Officer of Third Precinct.

The infectious disease returns from Anne Arundel county are classified as "good." They total 222 for the year 1912, as the following table will show:

COMMUNICABLE DISEASE CASES REPORTED IN ANNE ARUNDEL COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | .. | .. | 1 | 1 | .. | 2 | 10 | 27 | 17 | 4 | 5 | 1 | 68 |
| Scarlet fever | 8 | 2 | 4 | .. | 2 | 3 | 6 | .. | 2 | 11 | 3 | 1 | 42 |
| Diphtheria | 2 | 8 | 2 | 1 | .. | .. | 3 | .. | .. | 10 | 3 | 2 | 31 |
| Whooping cough | .. | 2 | .. | 3 | 4 | 9 | 7 | 4 | 12 | .. | .. | .. | 41 |
| Measles | .. | 1 | 1 | .. | .. | 5 | .. | 1 | .. | .. | .. | 1 | 9 |
| Chicken-pox | 1 | 5 | 1 | .. | .. | .. | .. | .. | .. | 3 | 3 | .. | 13 |
| Mumps | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | .. | 2 |
| Influenza | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | 3 | .. | .. | .. | 3 |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Erysipelas | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | .. | 1 |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | 4 | 2 | 5 | .. | .. | .. | 11 |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Pellagra | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Tetanus | .. | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | 1 |
| Total | 12 | 18 | 9 | 5 | 6 | 19 | 30 | 35 | 39 | 28 | 16 | 5 | 222 |

## BALTIMORE COUNTY.

Area in square miles, 646.8.

Population, 122,399.

Dr. Henry M. Slade, County Health Officer.
Dr. Marshall B. West, Health Officer of First District.
Dr. H. F. Shipley, Health Officer of Second District.
Dr. Henry A. Naylor, Health Officer of Third District.
Dr. Henry M. Slade, Health Officer of Fourth District.
Dr. C. E. Fouble, Health Officer of Fifth District.
Dr. Joseph Baldwin, Health Officer of Sixth District.
Dr. E. W. Heyde, Health Officer of Seventh District.
Dr. Benjamin Benson, Health Officer of Eighth District.
Dr. Claud C. Smink, Health Officer of Ninth District.
Dr. J. T. Payne, Health Officer of Tenth District.
Dr. James F. H. Gorsuch, Health Officer of Eleventh District.
Dr. Wm. E. McClanahan, Health Officer of Twelfth District.
Dr. Frank H. Ruhl, Health Officer of Thirteenth District.

Dr. Wm. F. Clayton, Health Officer of Fourteenth District.
Dr. John W. Harrison, Health Officer of Fifteenth District.
Dr. G. C. McCormick, Health Officer of Sixteenth District.

The infectious disease returns from Baltimore county are classified as "good," totaling 961 for the year 1912.

COMMUNICABLE DISEASE CASES REPORTED IN BALTIMORE COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | 40 | 27 | 9 | 20 | 6 | 7 | 21 | 75 | 65 | 61 | 13 | 17 | 361 |
| Scarlet fever | 55 | 25 | 10 | 4 | 3 | 6 | 7 | 4 | 15 | 9 | 11 | 12 | 161 |
| Diphtheria | 31 | 15 | 10 | 9 | 4 | 4 | 11 | 13 | 12 | 32 | 48 | 28 | 217 |
| Whooping cough | 4 | 3 | 2 | 2 | 6 | 6 | .. | 2 | 1 | 4 | 2 | 6 | 38 |
| Measles | 2 | 1 | 6 | 11 | 6 | 25 | 2 | 23 | .. | 2 | 2 | 7 | 87 |
| Chicken-pox | 18 | 3 | 13 | 3 | 4 | 2 | 1 | 1 | 1 | .. | 2 | 6 | 54 |
| Mumps | 2 | .. | 8 | 1 | 1 | 1 | .. | .. | .. | .. | .. | .. | 13 |
| Influenza | 1 | .. | .. | .. | 3 | .. | .. | .. | .. | .. | .. | .. | 4 |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | 1 | .. | 2 | .. | .. | .. | 2 | .. | 1 | 6 |
| Meningitis | .. | .. | .. | 1 | .. | .. | .. | .. | 1 | .. | .. | .. | 2 |
| Erysipelas | 2 | .. | .. | 1 | 1 | .. | 1 | .. | .. | .. | .. | .. | 5 |
| Anterior poliomyelitis | .. | .. | .. | .. | 1 | .. | 2 | 5 | .. | 1 | .. | 3 | 12 |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | 1 |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Pellagra | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | 155 | 74 | 58 | 53 | 35 | 53 | 45 | 124 | 95 | 111 | 78 | 80 | 961 |

## Calvert County.

Area in square miles, 216.8.

Population, 10,325.

Dr. I. N. King, County Health Officer.

The infectious disease returns from Calvert county are classified as "bad," totaling 71 for the year 1912.

COMMUNICABLE DISEASE CASES REPORTED IN CALVERT COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | 2 | .. | .. | .. | 1 | 2 | 5 | 13 | 2 | 9 | 6 | 2 | 42 |
| Scarlet fever | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Diphtheria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Whooping cough | .. | 5 | 3 | .. | .. | 1 | 1 | .. | .. | .. | .. | .. | 10 |
| Measles | .. | .. | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 |
| Chicken-pox | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | .. | 1 |
| Mumps | 4 | 3 | 2 | .. | .. | .. | .. | .. | 3 | .. | .. | .. | 12 |
| Influenza | 4 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 4 |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Erysipelas | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | 11 | 8 | 6 | .. | 1 | 3 | 7 | 13 | 5 | 9 | 6 | 2 | 71 |

## CAROLINE COUNTY.

Area in square miles, 317.4.

Population, 19,216.

Dr. J. R. Downes, County Health Officer.

The infectious disease returns from Caroline county are classified as "bad," totaling 76 for the year 1912.

COMMUNICABLE DISEASE CASES REPORTED IN CAROLINE COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | .. | .. | .. | .. | .. | .. | 1 | 3 | 4 | 13 | 12 | 1 | 34 |
| Scarlet fever | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | 1 | 3 | 5 |
| Diphtheria | .. | 2 | .. | .. | .. | .. | .. | 1 | 3 | 5 | 8 | 8 | 27 |
| Whooping cough | .. | .. | .. | .. | .. | .. | 4 | .. | .. | .. | .. | .. | 4 |
| Measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | 1 |
| Chicken-pox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 2 | 1 | 3 |
| Mumps | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | .. | 1 |
| Influenza | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Erysipelas | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | .. | .. | 1 |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | .. | 2 | .. | .. | .. | .. | 6 | 4 | 7 | 20 | 23 | 14 | 76 |

## CARROLL COUNTY.

Area in square miles, 445.3.

Population, 33,934.

Dr. Charles R. Foutz, County Health Officer.
Dr. Franklin H. Seiss, Health Officer of the First District.
Dr. Luther Kemp, Health Officer of the Second District.
Dr. G. Lewis Wetzel, Health Officer of the Third District.
Dr. Robert F. Wells, Health Officer of the Fourth District.
Dr. M. D. Morris, Health Officer of the Fifth District.
Dr. John F. B. Weaver, Health Officer of the Sixth District.
Dr. Charles R. Foutz, Health Officer of the Seventh District.
Dr. R. C. Wells, Health Officer of the Eighth District.
Dr. Edwin D. Cronk, Health Officer of the Ninth District.
Dr. Charles R. Diller, Health Officer of the Tenth District.
Dr. George H. Brown, Health Officer of the Eleventh District.
Dr. James Watt, Health Officer of the Twelfth District.
Dr. Irving D. Chaney, Health Officer of the Thirteenth District.
Dr. Daniel B. Sprecher, Health Officer of the Fourteenth District.

The infectious disease returns from Carroll county are classified as "good," totaling 277 for the year 1912.

COMMUNICABLE DISEASE CASES REPORTED IN CARROLL COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | 2 | 2 | 2 | 1 | .. | .. | 2 | 13 | 6 | 8 | 1 | .. | 39 |
| Scarlet fever | 3 | 2 | 7 | 2 | .. | .. | 3 | 3 | 1 | 28 | 1 | 2 | 57 |
| Diphtheria | 1 | 1 | 5 | 2 | 2 | 1 | 1 | 1 | 2 | 1 | .. | 5 | 45 |
| Whooping cough | 3 | .. | .. | .. | 19 | 25 | 17 | 9 | 3 | 2 | .. | 4 | 82 |
| Measles | 1 | 1 | 1 | .. | .. | 3 | 4 | .. | .. | .. | .. | .. | 10 |
| Chicken-pox | 3 | .. | 7 | .. | 4 | .. | .. | .. | .. | .. | 2 | .. | 16 |
| Mumps | .. | 15 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 15 |
| Influenza | .. | .. | .. | .. | .. | .. | .. | 2 | .. | .. | .. | 7 | 9 |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Erysipelas | .. | .. | .. | 1 | 1 | .. | .. | .. | .. | .. | .. | .. | 2 |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | 1 | 1 | .. | .. | .. | .. | 2 |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | 19 | 32 | 22 | 6 | 26 | 29 | 34 | 35 | 12 | 38 | 4 | 20 | 277 |

## Cecil County.

Area in square miles, 374.6.

Population, 23,759.

Dr. T. Jackson Conrey, County Health Officer.

The infectious disease returns from Cecil county are classified as "good," totaling 98 cases for the year 1912.

COMMUNICABLE DISEASE CASES REPORTED IN CECIL COUNTY. YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | 5 | 2 | 13 | 5 | 1 | 1 | 1 | 5 | 2 | 1 | 5 | 1 | 43 |
| Scarlet fever | 7 | 6 | 7 | 1 | .. | .. | .. | 1 | 1 | 1 | 4 | 2 | 30 |
| Diphtheria | 2 | 2 | .. | .. | .. | .. | .. | 1 | 1 | 1 | 1 | 4 | 12 |
| Whooping cough | .. | .. | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 |
| Measles | .. | 2 | .. | .. | 1 | .. | .. | .. | .. | .. | .. | .. | 3 |
| Chicken-pox | .. | 3 | .. | .. | .. | .. | .. | .. | .. | .. | .. | 6 | 9 |
| Mumps | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Influenza | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Erysipelas | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | 14 | 15 | 21 | 6 | 2 | 1 | 1 | 7 | 4 | 3 | 11 | 13 | 98 |

## Charles County.

Area in square miles, 462.

Population, 16,386.

Dr. Ernest Spencer, County Health Officer.

The infectious disease returns from Charles county are classified as "very bad," totaling only 47 for the year 1912.

COMMUNICABLE DISEASE CASES REPORTED IN CHARLES COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | 3 | .. | .. | .. | 1 | .. | 4 | 3 | .. | 7 | 7 | 4 | 24 |
| Scarlet fever | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 4 | 4 |
| Diphtheria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | .. | 1 |
| Whooping cough | 7 | .. | .. | .. | .. | .. | 1 | .. | .. | .. | 4 | .. | 12 |
| Measles | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | .. | .. | 1 |
| Chicken-pox | 1 | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | 3 | 5 |
| Mumps | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Influenza | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Erysipelas | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | 11 | 1 | .. | .. | 1 | 1 | 5 | 3 | .. | 7 | 7 | 11 | 47 |

## DORCHESTER COUNTY.

Area in square miles, 573.2.
Population, 28,669.

Dr. Victor C. Carroll, County Health Officer.
Dr. E. E. Wolff, Health Officer of Cambridge.

The infectious disease returns from Dorchester county are classified as "good," totaling 186 for the year 1912.

COMMUNICABLE DISEASE CASES REPORTED IN DORCHESTER COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | 7 | .. | .. | .. | 1 | 1 | 25 | 60 | 16 | 28 | 6 | 9 | 153 |
| Scarlet fever | 6 | 1 | 2 | .. | .. | .. | .. | .. | .. | 2 | .. | 1 | 12 |
| Diphtheria | 3 | 1 | .. | 1 | .. | .. | .. | .. | .. | 1 | 3 | 3 | 12 |
| Whooping cough | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Measles | .. | .. | .. | .. | 6 | .. | .. | .. | .. | .. | .. | .. | 6 |
| Chicken-pox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | 1 |
| Mumps | .. | .. | .. | .. | 1 | .. | .. | .. | .. | .. | .. | .. | 1 |
| Influenza | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | 1 |
| Erysipelas | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | 16 | 2 | 2 | 1 | 8 | 1 | 25 | 60 | 16 | 31 | 9 | 15 | 186 |

## FREDERICK COUNTY.

Area in square miles, 660.
Population, 52,673.

Dr. James M. Goodman, County Health Officer.
Dr. Ira J. McCurdy, Health Officer of Frederick.
Dr. Levin West, Health Officer of Brunswick.

The infectious disease returns from Frederick county are classified as "good," totaling 364 for the year 1912.

COMMUNICABLE DISEASE CASES REPORTED IN FREDERICK COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | 12 | 2 | 6 | 3 | 4 | 4 | .. | 24 | 42 | 33 | 10 | 4 | 134 |
| Scarlet fever | 33 | 4 | .. | 3 | 1 | .. | 2 | .. | 3 | 8 | 14 | 15 | 53 |
| Diphtheria | 5 | 1 | 1 | 2 | 1 | 1 | 2 | 8 | 9 | 6 | 11 | 4 | 51 |
| Whooping cough | 1 | 2 | 2 | 5 | 23 | 11 | 2 | .. | 9 | 4 | 3 | .. | 62 |
| Measles | .. | .. | 10 | 34 | 1 | .. | .. | .. | .. | .. | 2 | 3 | 50 |
| Chicken-pox | .. | .. | 1 | 1 | 5 | .. | .. | 2 | .. | .. | .. | .. | 9 |
| Mumps | .. | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 |
| Influenza | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | .. | 1 |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | 1 |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Erysipelas | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | .. | 1 | 1 | .. | .. | 2 |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | 11 | 10 | 20 | 48 | 35 | 16 | 7 | 34 | 65 | 52 | 40 | 26 | 364 |

## Garrett County.

Area in square miles, 681.
Population, 20,105.

Dr. N. I. Broadwater, County Health Officer.

The infectious disease returns from Garrett county are classified as "very bad," totaling but 23 for the entire year of 1912.

COMMUNICABLE DISEASE CASES REPORTED IN GARRETT COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | .. | .. | .. | .. | .. | 4 | 1 | .. | 2 | .. | 6 | 3 | 16 |
| Scarlet fever | .. | .. | .. | .. | .. | .. | .. | .. | 1 | .. | 1 | .. | 2 |
| Diphtheria | .. | .. | .. | .. | .. | .. | .. | .. | 1 | .. | 1 | .. | 2 |
| Whooping cough | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Measles | .. | .. | .. | .. | .. | .. | 3 | .. | .. | .. | .. | .. | 3 |
| Chicken-pox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Mumps | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Influenza | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Erysipelas | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | .. | .. | .. | .. | .. | 4 | 4 | .. | 4 | .. | 8 | 3 | 23 |

## Harford County.

Area in square miles, 439.8.
Population, 27,965.

Dr. H. Lee Hughes, County Health Officer.
Dr. F. W. Steiner, Health Officer of Havre de Grace.
Dr. Charles R. Kriete, Health Officer of Aberdeen.

The infectious disease returns from Harford county are classified as "bad," totaling but 74 for the year 1912.

COMMUNICABLE DISEASE CASES REPORTED IN HARFORD COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | 1 | .. | .. | .. | 1 | .. | 1 | 1 | 4 | 6 | 3 | .. | 17 |
| Scarlet fever | 7 | 3 | .. | 9 | .. | .. | 4 | .. | .. | .. | .. | 4 | 27 |
| Diphtheria | 2 | 1 | 4 | 1 | .. | .. | 1 | .. | .. | 4 | .. | 1 | 14 |
| Whooping cough | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Measles | .. | 2 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 2 |
| Chicken-pox | 1 | 7 | 3 | .. | .. | .. | .. | .. | .. | .. | .. | .. | 11 |
| Mumps | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Influenza | .. | 1 | .. | 1 | .. | .. | .. | .. | .. | .. | .. | .. | 2 |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Erysipelas | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | 12 | 14 | 7 | 11 | 1 | .. | 6 | 1 | 4 | 10 | 3 | 5 | 74 |

## HOWARD COUNTY.

Area in square miles, 249.1.
Population, 16,106.

Dr. Wm. C. Stone, County Health Officer.
Dr. Wm. R. Eareckson, Health Officer of First District.
Dr. Wm. C. Stone, Health Officer of Second District.
Dr. B. F. Shipley, Health Officer of Third District.
Dr. J. W. Sims, Health Officer of Fourth District.
Dr. S. A. Nichols, Health Officer of Fifth District.
Dr. T. W. Linthicum, Health Officer of Sixth District.

The infectious disease returns from Howard county are classified as "good," totaling 110 for the year 1912.

COMMUNICABLE DISEASE CASES REPORTED IN HOWARD COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | 3 | 3 | 3 | 2 | .. | .. | 12 | 6 | 7 | 7 | 2 | 2 | 37 |
| Scarlet fever | .. | 1 | 1 | .. | .. | .. | 5 | .. | .. | .. | .. | .. | 7 |
| Diphtheria | 5 | 2 | 3 | .. | .. | .. | 2 | .. | .. | .. | 1 | .. | 13 |
| Whooping cough | 13 | 6 | 2 | 1 | .. | .. | .. | .. | 5 | .. | 3 | 1 | 31 |
| Measles | 1 | .. | 4 | .. | .. | .. | .. | .. | .. | .. | .. | .. | 5 |
| Chicken-pox | 6 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | 7 |
| Mumps | .. | .. | .. | 1 | .. | .. | .. | 2 | .. | 6 | .. | .. | 9 |
| Influenza | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | 1 |
| Erysipelas | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | 28 | 12 | 13 | 4 | .. | .. | 9 | 8 | 12 | 13 | 6 | 5 | 110 |

## Kent County.

Area in square miles, 281.
Population, 16,957.

Dr. George R. Jones, County Health Officer.

The infectious disease returns from Kent county are classified as "bad," totaling but 74 for the year 1912.

COMMUNICABLE DISEASE CASES REPORTED IN KENT COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | .. | .. | .. | .. | .. | 2 | 5 | 2 | 8 | 10 | 10 | 3 | 40 |
| Scarlet fever | 2 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | 3 |
| Diphtheria | 10 | 4 | .. | 1 | 1 | .. | .. | .. | .. | 4 | 4 | 1 | 25 |
| Whooping cough | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Measles | .. | .. | .. | .. | .. | 1 | 1 | 1 | 1 | .. | .. | .. | 4 |
| Chicken-pox | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | 1 | .. | 2 |
| Mumps | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Influenza | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Erysipelas | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | 12 | 4 | .. | 1 | 1 | 3 | 6 | 3 | 9 | 15 | 15 | 5 | 74 |

## Montgomery County.

Area in square miles, 517.6.
Population, 32,089.

Dr. C. H. Mannar, County Health Officer.
Dr. William L. Lewis, Health Officer of Kensington.
Mr. H. E. Rogers, Health Officer of Takoma Park.

The infectious disease returns from Montgomery county are classified as "good," totaling 144 for the year 1912.

COMMUNICABLE DISEASE CASES REPORTED IN MONTGOMERY COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | 4 | .. | 1 | .. | 1 | .. | 3 | 9 | 15 | 2 | .. | .. | 35 |
| Scarlet fever | .. | 1 | .. | .. | .. | .. | 2 | .. | .. | 1 | 4 | .. | 8 |
| Diphtheria | 1 | 2 | .. | 6 | .. | .. | .. | 1 | 6 | .. | 2 | 1 | 19 |
| Whooping cough | 4 | .. | 15 | .. | 13 | 3 | .. | .. | .. | .. | .. | 3 | 38 |
| Measles | .. | .. | .. | .. | 1 | 1 | 1 | .. | .. | 1 | .. | .. | 4 |
| Chicken-pox | 2 | .. | 1 | 1 | .. | 3 | .. | .. | .. | .. | .. | .. | 7 |
| Mumps | .. | .. | .. | 1 | .. | .. | .. | 2 | .. | .. | .. | .. | 3 |
| Influenza | .. | .. | 20 | 2 | .. | .. | .. | .. | .. | 1 | .. | .. | 23 |
| German measles | .. | .. | .. | .. | 7 | .. | .. | .. | .. | .. | .. | .. | 7 |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Erysipelas | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | 11 | 3 | 37 | 10 | 22 | 7 | 6 | 12 | 21 | 5 | 6 | 4 | 144 |

REFERENCES.

[41]The total number of cases of sickness from communicable diseases reported in 1911 was 6609; by including the 509 cases of tuberculosis sent in by county physicians, the figures are raised to 7118. In 1912 a total of 5727 cases of sickness from communicable diseases was reported, which number is swollen to 6249 when the county tuberculosis cases (522) are included. For purposes of demonstration and comparison, these figures will next be set forth in tabular form.

CASES OF SICKNESS FROM COMMUNICABLE DISEASES IN THE COUNTIES OF MARYLAND FOR 1912, 1911, 1910, 1909 AND 1908.

| Name of disease. | Year of 1912. | Year of 1911. | Year of 1910. | Year of 1909. | Year of 1908. |
|---|---|---|---|---|---|
| Typhoid fever | 1,697 | 1,980 | 2,348 | 1,977 | 1,647 |
| Measles | 1,675 | 1,706 | 1,323 | 2,471 | 2,047 |
| Diphtheria | 784 | 783 | 600 | 614 | 642 |
| Scarlet fever | 608 | 653 | 682 | 588 | 572 |
| Whooping cough | 441 | 453 | 734 | 355 | 355 |
| Chickenpox | 251 | 274 | 215 | 229 | 115 |
| Mumps | 103 | 605 | 243 | 91 | 101 |
| Influenza | 61 | 41 | 92 | 21 | 17 |
| Anterior poliomyelitis | 32 | 12 | 33 | 0 | 0 |
| Smallpox | 20 | 31 | 6 | 16 | 33 |
| Erysipelas | 18 | 15 | 15 | 18 | 9 |
| Malaria | 14 | 27 | 7 | 5 | 8 |
| German measles | 11 | 13 | 56 | 21 | 73 |
| Meningitis | 6 | 8 | 2 | 6 | 8 |
| Septicemia | 4 | 1 | 1 | 3 | 0 |
| Acute dysentery | 1 | 3 | 0 | 0 | 0 |
| Trachoma | 1 | 0 | 0 | 0 | 0 |
| Glandular fever | 0 | 0 | 0 | 0 | 6 |
| Pellagra | 0 | 3 | 0 | 0 | 0 |
| Tetanus | 0 | 1 | 0 | 0 | 0 |
| Impetigo contagiosa | 0 | 0 | 0 | 58 | 1 |
| Catarrhal conjunctivitis | 0 | 0 | 0 | 2 | 47 |
| Ringworm | 0 | 0 | 0 | 0 | 180 |
| Contagious jaundice | 0 | 0 | 0 | 0 | 15 |
| Yearly totals | 5,727 | 6,609 | 6,357 | 6,475 | 5,876 |

[42]The figures which I have given above, as well as those which follow for the respective counties, are the accurate and revised ones. Ordinarily, however, the areas in square miles are given in round numbers as follows: The gross area of the State is 12,210 square miles, of which 9860 square miles are land surface and 2350 square miles are water surface. Of the latter the included portion of the Chesapeake Bay is 1203 square miles; Assateague Bay, on the Atlantic coast, 93 square miles, with 1054 square miles of smaller estuaries and rivers.

*(To be continued.)*

## Book Reviews.

INTERNATIONAL CLINICS. Volume XI. Twenty-third Series. Philadelphia and London: J. B. Lippincott Company. Cloth, $2 net. 1913.

For review, see editorial.

SOME DONT'S. Medical and Surgical. New York: The Fellows Company.

This little brochure is full of brief cautionary aphorisms which should prove of inestimable value to those who are inclined to rush where angels fear to tread. It is a well-known fact that most of the mistakes of the profession are of omission rather than commission; nevertheless, there are times when it is better to omit than commit, and it is with these occasions that this booklet deals. As an example of its advice, we excerpt the following: "Appendicitis Don'ts." Don't give any food or even water by mouth; don't give too favorable a prognosis, even if the case seems to be a mild one, etc. The brochure is full of such good healthful advice, and is well worth the time necessary to completely read it.

# MARYLAND MEDICAL JOURNAL

NATHAN WINSLOW, M.D., *Editor.*

*Associate Editors:*

THOMAS R. BROWN, M.D.
HUGH H. YOUNG, M.D.
RICHARD H. JOHNSTON, M.D.
JOSE L. HIRSH, M.D.
ALEXIUS MCGLANNAN, M.D.
A. SAMUELS, M.D.

BALTIMORE, AUGUST, 1913

THE present number of International Clinics contains so much of interest to the doctor, ordinary doctor, family physician, surgeon and specialist that we feel constrained to give it a more prominent place than in the Book Review column. Do not think for one minute, however, that the present volume is a marked exception to its fellows, for such is not the case, the editor, Dr. Cattell, being an extremely good judge of what the doctor needs, and in each issue has several articles of more than usual merit. Volume XI, twenty-third series, however, is full of useful practical papers by eminent authorities, rendering it slightly more attractive than some of its predecessors. The frontispiece is a beautiful colored illustration, depicting a giant celled sarcoma of the finger. The very first article should appeal to the practitioner. It deals with "The Therapeutic Indications for Antitoxins, Serums and Vaccines." These agents have come into such general use and application that they should be better understood than heretofore if the best results are to be obtained from their use. The author rightly says: "The proper use of antitoxins, serums and vacvines is a subject that is rapidly becoming of vital interest both to the specialist and the general practitioner who are ambitious to apply for the relief of their patients the various reliable products of the modern laboratory, and the question will therefore be treated to avoid as much as possible intricate laboratory methods, difficult nomenclature and phylacogenetic discussion."

The writer predicts that the marvelous strides made by this method of treatment will be still further augmented in the future, when all cases of infection will be treated, diagnosed or prevented by the use of an antitoxin, serum or bacterin, to the partial or com-

plete exclusion of drugs formerly used for this purpose. When vaccines are indicated, the writer states that autogenous preparations are by far the more rational, scientific and successful in their effect upon a given condition, and should always be first thought of. In those instances in which time is an important factor, stock preparations are recommended, as, for instance, septic conditions and lobar pneumonia, or in cases in which cultures cannot be obtained, at any rate until the time when autogenous cultures can be prepared. The author declares that many instances of failure in vaccine-treated can be attributed to the use of too old cultures, *i. e.*, the injection of a gonococcic vaccine produced from a series of cultures extending over a period of several months into an individual suffering with an acute urethritis. The writer then takes up seriatim those maladies in which he has found these agents to be of use, and explicitly and minutely describes the technic. Another article which should appeal to the general reader is "The Treatment of the Common Animal Parasitic Diseases, Including Grain Itch," by Frank Crozer Knowles, instructor in dermatology, University of Pennsylvania. It is an article distinctly for the general practitioner, being written in simple language and directed toward the treatment of such conditions as scabies, pediculosis corporis, etc. It contains hints which will prove useful to every family doctor. The paper on "Psychoneuroses in the Male," by James J. Walsh, is timely, as it directs attention to the manifold increase of neuroses in the male. The article states that the condition is more prevalent in Europe than in our country, but that it is not limited to country or any age. In our modern day, the writer says, the most fruitful source of these psychoneuroses is undoubtedly found in the environment of a man who has been developing his muscular system either by actual hard work or by athletics, and then is confined to an office or to very narrow quarters, which give him little or no opportunity to utilize his muscular energy. The author then discusses a number of cases which he has seen in active walks of life. Before concluding the article he warns against overlooking kidney degeneration or some condition of the heart or liver in men past 40 who complain of tired feelings, disturbed sleep and loss of appetite. Other articles of interest are "The Prevention of Eclampsia," "Medical Application of Radioactive Elements," and "Diagnosis of Diseases of the Heart."

# Medical Items.

Dr. Robert Hoffmann of 1325 Park avenue will go abroad in August.

Frank R. Eldred, director of the scientific division of Eli Lilly & Co., received the degree of doctor of pharmacy from the Medico-Chirurgical College of Philadelphia at the June commencement. Mr. Eldred is well known in pharmaceutical and chemical circles by reason of his investigations which have been published from time to time by the pharmaceutical and chemical press.

Dr. Clement A. Penrose, Johns Hopkins Medical School, '97, of 21 West Mt. Royal avenue, left July 2 for Siasconset, Mass., where he will spend the summer with his family.

Dr. J. S. Ames, director of the physical laboratory of Johns Hopkins University, has made a study of the proposed post-graduate department at the Naval Academy, and has given his unqualified endorsement to the proposal. Secretary of the Navy Daniels is much pleased with the expert opinion of Dr. Ames.

Dr. Thomas P. Sprunt of the Johns Hopkins University has been appointed professor of pathology in the graduate school of medicine of the University of Alabama, Mobile, Alabama.

Among those who attended the May dinner of the South River Club of Anne Arundel county, Maryland, were Dr. James D. Iglehart, Dr. Murray Cheston and Dr. Richard Hill.

A daughter, Winifred Holt, was born recently to Dr. Joseph C. Bloodgood, associate professor of surgery, Johns Hopkins Hospital, and Mrs. Bloodgood.

Dr. C. C. Haskell, Director of the Department of Experimental Medicine, Dr. Severance Burrage, Director of the Biological Department, and Dr. C. S. Woods, medical counsel, all of Eli Lilly & Co., attended the meeting of the American Medical Association at Minneapolis during the week of June 16.

Dr. William Stevenson Baer, Johns Hopkins University, '98, 4 East Madison street, was recently offered the chair of orthopedic surgery in the Leland Stanford Junior University, California. In spite of the compliment attached to this offer, Dr. Baer's friends are rejoicing in the fact that he has seen fit to decline and will remain in Baltimore, where he is associate professor of orthopedic surgery at Hopkins.

Dr. Hiram Woods, University of Maryland, '82, professor of eye and ear diseases, attended the meeting of the American Medical Association, which met in Minneapolis, June 13. Among the Baltimoreans he met at the convention were Drs. Randolph Winslow, Thomas S. Cullen, Hugh Young, William S. Thayer and C. Hampson Jones.

The engagement is announced of Dr. Louis M. Allen, University of Maryland, '96, of Winchester Va., to Miss Dorothy Gilpin. The wedding will take place shortly after Christmas in Christ Protestant Episcopal Church at Millwood, Va., and will be a typical Virginia one. Dr. Allen and his bride will live in Winchester, where Dr. Allen is practicing his profession.

Major Roger Brooke, M.C., U. S. A., Baltimore Medical College, 1900, is stationed at the Presidio, San Francisco. He has spent much of his time since graduation in the Philippines, and paid a recent visit East. While in Baltimore he visited the college and hospital.

Dr. Ernest Rowland, Baltimore Medical College, '95, is president of the Cecil County Medical Society.

Dr. Horace M. Simmons, former editor of Maryland Medical Journal and later associated with the *Hygienic and Dietetic Gazette*, and Mrs. Simmons, are spending some time in California. At present they are stopping at 5971 Chula Vista Way, Los Angeles.

Dr. A. L. Walters will become connected with the Department of Experimental Medicine of Eli Lilly & Co. in July. Dr. Walters is a graduate of Purdue University with a degree of B. Sc. in 1904, and spent the four years following his graduation in the Botanical Department of the Lilly company. In 1908 he resigned to enter the medical department of Johns Hopkins University, and received the degree of doctor of medicine in 1912, since which time he has been engaged in hospital work as an interne at the Providence City Hospital, R. I., and at the Johns Hopkins Hospital, Baltimore.

In addition to his medical training, Dr. Walters is also a graduate pharmacist, and is especially qualified to carry on work in experimental medical lines.

Dr. H. Warren Buckler of 806 Cathedral street is spending the summer with his family at Jamestown, R. I.

Dr. Randolph Winslow, University of Maryland, '73, professor of surgery, who has

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been on an extended trip through the West, has returned home. While at Spokane, Wash., he saw Dr. A. Aldridge Matthews, formerly superintendent of the University Hospital.

Dr. Reid Hunt, U. S. P. H., Physicians and Surgeons, '96, formerly of Johns Hopkins University, has been appointed a professor in Hartford University. For some years Dr. Hunt has been connected with the Bureau of Hygiene, Washington, D. C.

Dr. H. Arthur Mitchell of Elkton has been designated as a personal aide to General Charles D. Gaither, Maryland National Guard.

Dr. William H. Welch, chairman of the administrative committee Johns Hopkins University, sailed July 1 on the steamship Kronprinz Wilhelm for Bremen. Dr. Welch will spend the summer abroad, the greater part of which will be spent in Germany, returning to this country in the fall.

Dr. J. Morris Slemmons, Johns Hopkins Medical School, 1901, associate professor of obstetrics at Johns Hopkins University and one of the most prominent obstetricians in the city, has accepted a chair in the University of California, at San Francisco. His associate will be Dr. Arthur H. Morse, also a graduate of the Johns Hopkins Medical School, 1908, who will accompany him. Dr. Carl M. Wilson, a former resident physician at Hopkins Hospital, will succeed Dr. Slemmons.

Dr. Henry Barton Jacobs, of 11 Mt. Vernon Place, is spending the summer at Newport.

The Medical Association of Howard County held its second annual banquet at Ellicott City, Md., June 12, 1913, at the Howard House. Dr. William Magruder of Olney, Montgomery county, was the oldest practicing physician present. He is nearly 80 years of age, and is still very active. Among the speakers were the following: Dr. W. Rushmere White, president; Dr. Randolph Winslow, Dr. Alfred Gundry, Dr. Morris Bierly, Dr. Richard Batson, Dr. William Magruder, Dr. William T. Taylor, Dr. Charles W. McElfresh, Dr. J. Morley Hoag and Dr. William B. Gambrill.

Dr. W. B. Wolf of 113 West Franklin street has leased a house at Catonsville, Md., for the summer.

Dr. Charles W. Young, professor of bacteriology and pathology in the Union Medical College, Pekin, China, who has been in this country since last August on leave of absence, has returned to China. He came here expressly to buy classroom supplies for his college. Before leaving, he gave an illustrated lecture on the plague epidemic before the Epworth League, this city.

Dr. Joseph C. Bloodgood and Mrs. Bloodgood are spending the summer at Roland Park.

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### MARRIAGES.

Paul Brown, M.D., University of Maryland, '09, formerly of Gaffney, S. C., to Miss Viola Edmondson of Baltimore, Md. at Baltimore, June 25, 1913. They left immediately for a Southern trip, and upon their return will live at 1841 Pennsylvania avenue, Baltimore, where the groom is practicing his profession.

Claud C. Smink, M.D., University of Maryland, '09, of Lauraville, Md., to Miss Sarah Lillian Long of Westover, Md., at Westover, June 30, 1913. After a wedding trip to Atlantic City and other points, Dr. and Mrs. Smink will reside at Lauraville, Md.

George A. Anderton, Baltimore Medical College, '07, of Morris Plains, N. J., to Miss Minnie P. Newman of Catonsville, Md., at Catonsville, June 25, 1913. Dr. and Mrs. Anderton will reside at Greystone Park, N. J., where Dr. Anderton is connected with the New Jersey State Hospital.

James Emery Rawlings, M.D., University of Maryland, '04, of Daytona, Fla., to Miss Madge Mogee of Morristown, Pa., at Morristown, May 22, 1913.

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### DEATHS.

Edward L. Downs, M.D., University of Maryland, '86, died at Butler, Pa., March 27, 1913, aged 55 years.

Horace Jayne, M.D., post-graduate student, Johns Hopkins University, of Wallingford, Pa., died suddenly at his home in Wallingford, July 8, 1913, aged 55 years.

W. F. A. Kemp, M.D., University of Maryland, '72, of Baltimore, Md., died at his home, 8 West 25th street, this city, July 10, 1913, aged 64 years. Dr. Kemp was for many years treasurer of the Medical and Chirurgical Faculty.

Osis Guy Brinkley, M.D., Physicians and Surgeons, '02, of Nansemond county, Va., died suddenly at Savannah, Ga., June 17, 1913, aged 40 years. Dr. Brinkley was a specialist in cancer and skin diseases, and had been practicing in Savannah for seven years. He was shot and killed by a patient in his office.

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# OBSERVATIONS ON THE ACTION OF DIGITALIS.

*By Wilfred M. Barton, M.D.,*
Associate Professor of Medicine, Medical Department Georgetown University, Washington, D. C.

Digitalis was introduced into therapeutics by Withering in the latter part of the eighteenth century. It is true that Withering[1] himself was most impressed by the diuretic properties of the drug, but he nevertheless commented upon the beneficial effects of digitalis in cases of heart failure. Before the end of the eighteenth century Ferriar (1799) distinctly emphasized its power to slow the pulse. At the very commencement of the nineteenth century another idea was added to the pulse-slowing conception of digitalis action. Beddoes[2] and Kingslake[3] in 1801 concluded from their investigations, in conformity with those of their predecessors, that digitalis slows the pulse rate, but they brought out the further fact that the strength of the pulse beat is increased. This discovery, however, seems to have made but little impression at the time, and the idea that digitalis acts upon the heart as a sedative became more and more predominant, the principle criterion for this view being, of course, the slowing of the pulse. Corrigan,[4] in 1832 emphasized the power of digitalis to slow the heart, and was so much impressed by this fact that he advised against the use of the drug in aortic regurgitation because of the slowing of the heart and consequent prolongation of the diastolic period.

Bouilland[5] in 1835 commented upon the effects of digitalis, calling it "ce grand moderateur, cette sorte d'opium du coeur" (the great sedative, the opium of the heart), and Pareira,[6] in 1840, must have been a strong believer in the sedative effects of digitalis on the heart, for he recommended it in aneurysm and hemorrhage to reduce the force of circulation.

Twenty-one years later (1871) we find Traube[7] upholding the sedative view, and advancing the theory that the sedative effect of digitalis is due to the stimulation of the vagus center in the medulla.

Thus we see that digitalis, during the century immediately following its introduction into therapeutics, was considered pre-emi-

nently a cardiac sedative, and that feature of its action which attracted the most attention was its power to slow the pulse. The accepted explanation for the slowing, which, indeed, appeared entirely adequate, was vagus stimulation.

Then began a period in which the prevailing conceptions of digitalis action were considerably modified. Indeed, in some respects, it might be said that they were so radically changed as to constitute an almost opposite view.

Schmiedeberg[8] demonstrated in 1874 that, in the frog's heart, digitalis not only slows the rate by vagus stimulation, but that it acts directly upon the cardiac muscle, increasing the force of the contractions. Other investigators, notably Cushny,[9] corroborated these findings, and at the end of the nineteenth century we find the view universally held that the action of digitalis is compounded of vagus stimulation plus a direct action upon the cardiac muscle, the latter consisting of a strengthening of the ventricular contraction and a lessening of ventricular relaxation. It was also found in animal experiments that the vessels in the splanchnic area are constricted through stimulation of the vasomotor center, and perhaps also through a direct action on the vessel wall, the result of which is a rise in the blood pressure. It was reasoned that the net result of these effects must naturally be an increased output of blood from the heart, and that the beneficial results of digitalis in cases of heart failure must, therefore, necessarily be due to a combination of these factors. The dilated heart is contracted, the weakened contractions are reinforced, the coronary circulation is improved; hence the nutrition of the muscle is increased, the slower heart allows a more complete filling of the chambers, the more vigorous contraction insures their more complete discharge. In other words, the findings of experimental pharmacology were carried over into clinical medicine, and the explanation of the good effects of digitalis on heart failure seemed absolutely clear.

It will, therefore, be seen that the work of Schmiedeberg and Cushny—there might also be mentioned others who contributed largely to the subject—tended to develop a conception of digitalis action quite at variance with that which had been previously held. If digitalis increases the force of the muscular contractions, constricts the vessels and raises the blood pressure, it must be regarded not as a sedative, but as a stimulant to the heart. This view became predominant over the sedative view which had ruled over the first century of digitalis use after the days of Withering.

Such, briefly, is the history of the development of ideas upon the action of digitalis up to very recent times.

The views entertained at present concerning the action of digitalis may be said to have largely emerged from those which have been detailed above. So far as the work of the experimental pharmacologist is concerned, the matter seems to be definitely settled. In healthy lower animals, when digitalis is injected into

the circulation, the rate of the beat is slowed, the strength of the ventricular contraction is increased, the ventricular relaxation is diminished, the peripheral vessels are constricted and the blood pressure raised. Although the experiment has never been tried, there is no reason to doubt that in healthy human beings, under the same conditions, the same results would be obtained.

But, obviously, in the therapeutic applications of digitalis these conditions do not obtain. The hearts which are treated by the medical practitioner are affected by a great variety of pathological lesions, and the drug is never introduced in large quantities directly into the circulation.

Obviously, also, the methods which are available in the laboratory for the study of the action of drugs are not available in the clinic, and as most of the clinical investigations upon digitalis have, up to a few years ago, been made without instruments of precision, or without any careful differentiation of the various clinical types of heart disease, it is little wonder that the results were meager and confusing. With the advent of the polygraph and electrocardiograph conditions have changed. From a mass of confusing data and chaotic opinion order and clearness have arisen. Certain clinical types of arrythmia have been definitely classified, and we now speak of auricular fibrillation, premature contractions, sinus arrythmia, heart block, paroxysmal tachycardia, auricular flutter, pulsus alternans as definite semiological types with definite clinical characteristics and reasonably well-known pathological associations. The heart is recognized as a complex organ, made up of histologically differentiated tissue, possessed of not less than five different functions, and capable of originating, feeling, transmitting, actuating and co-ordinating the wonderful species of energy upon which its activity depends.

With the stupendous developments in cardiopathology which have taken place in recent years has also arisen a clearer conception of the action of digitalis in heart disease.

With these developments, both as regards the clinical pathology of the cardiopathies and likewise the application of digitalis to their treatment, the name of Mackenzie[10] will always be associated as pioneer in the minds of English-speaking physicians. To him we owe the creation of auricular fibrillation as a distinct and important clinical type of cardiopathy, though he did not originate the name, but called the condition nodal rhythm in his earlier work. To him, also, we owe the knowledge of the fact that it is in this particular class of cases, namely, auricular fibrillation, that digitalis is so signally effective.

Mackenzie[10] thus expresses the fact: "I have been able to separate from the numerous patients to whom I have given digitalis one group in particular, where the reaction in the heart is so striking as to enable us to recognize the kind of heart in which a beneficial reaction may be expected. It has been known for a long while that digitalis acts upon certain hearts very speedily, causing

great slowing in their rate, and at the same time remarkable improvement in the patient's condition. The class of patients in whom this occurs is limited almost entirely to patients with auricular fibrillation."

Mackenzie also discovered that, so far as the heart's rate is concerned, the reaction to digitalis is less effective when the rhythm is normal; that is to say, when the auricles are not fibrillating. Likewise it soon became appreciated that digitalis has little effect upon the rate of the heart, whether there is auricular fibrillation or not, if the heart is under the influence of intoxications, such as alcohol, or the poisons of acute infectious disease.

It was soon discovered that in patients with the normal rhythm digitalis tends to induce irregularity, notably sinus irregularities, extra systoles, heart block and pulsus alternans.

As experience in the use of digitalis increased it became evident that the drug is of little, if any, service in the treatment of sinus arrythmia, heart block, paroxysmal tachycardia and pulsus alternans. In other words, there is only one kind of cardiac irregularity in which digitalis is effective, and this is auricular fibrillation. To this may possibly be added auricular flutter, a clinical type of arrythmia which has only very recently been discovered.

In auricular fibrillation the effect of digitalis is magical. In scarcely any other disease can the physician point with such confidence to the effect of his remedies. As a result of the intelligent use of digitalis in these cases the moribund may be restored to life and many years of comparative activity added to their existence.

There is little wonder that we should all be interested in this clinical fact, and, so far as our present conception of the action of digitalis from a clinical standpoint is concerned, our chief interest resides in explaining the marvelous effects of the drug in auricular fibrillation, since in other species of arrythmia it is practically useless, if not, under many circumstances, positively harmful, and in cases of decompensation, where the rhythm is normal, the results from digitalis are never so brilliant as in auricular fibrillation.

A small group of cases, however, even of auricular fibrillation, are not affected by digitalis. These are usually persons of advanced years, in whom a considerable degree of cardiosclerosis exists.

Experience has shown that a reaction to digitalis in cases of auricular fibrillation bears some relation to the amount of healthy cardiac tissue present. It is in the young that the most striking results are obtained, whereas in the senile heart which has undergone extensive degeneration digitalis may have little effect or fail altogether.

How, then, shall we explain the slowing of the rate and the beneficial effects which are observed when digitalis is administered in cases of auricular fibrillation?

The most natural assumption would seem to be to regard the

slowing as due to vagus stimulation, and this is the opinion that has been generally held. There is, however, another explanation. The slowing might be due to direct effects upon the muscle.

It was Lewis[11] who first suggested that the real explanation of the pulse slowing by digitalis in cases of auricular fibrillation is a lessening of conductivity of the auriculo-ventricular bundle of His. If this is the true explanation of the slowing, then it is also the true reason for the beneficial effects which accrue from the use of the drug.

Several experimenters have attempted quite recently to solve this problem, among whom may especially be mentioned Cushny and Mackenzie and their coworkers, Lewis, Morris, Silberberg, Price and others.

One method, though an indirect one, of solving the problem, which was early suggested, was to try in cases of auricular fibrillation the effects of drugs which stimulate the vagus center like digitalis, but which are known to have no direct effect on the muscle. Such a pure vagus stimulant is aconite. The drug was tried in a number of cases of fibrillation by Price, but no slowing of the pulse was observed and no beneficial effects were obtained. This is, of course, negative evidence in favor of the supposition that the action of digitalis is not confined to vagus action.

Another method was to try the effects of drugs which act like digitalis on the heart muscle, but which are devoid of vagus action. Cushny selected helleborein for this purpose, but in experiments with the drug upon cases of heart failure it was found that it induced diarrhea before it could be given in sufficient amount to produce any demonstrable effect upon the disease.

These methods of distinguishing whether the therapeutic effects of digitalis are due to inhibition or to muscle action having failed, another method was tried, and this proved more successful. It consisted in removing the inhibitory action of digitalis with atropine, which, as is well known, paralyzes the peripheral terminations of the vagus in the heart and eliminates all impulses through the pneumogastric nerve. If, now, after having removed all inhibitory action, digitalis should still be found to retain its therapeutic effects in auricular fibrillation, then it would be proven that these effects are not dependent upon inhibition, and must, therefore, reside in the muscle action.

In 10 cases of auricular fibrillation Cushny[12], Morris and Silberberg tried this experiment. Atropine was used before the administration of digitalis to determine the amount of vagus tone in each case. Atropine accelerated the pulse before digitalis in all 10 cases, showing that the natural tone of the vagus was good even though the auricles were fibrillating. Digitalis produced slowing and improvement of symptoms in all 10 cases. While the digitalis was being used, atropine was administered and the amount of acceleration noted.

Now, if the action of digitalis in slowing the heart is due to

stimulation of the vagus, and hence to an increase in inhibition tone, then the effect of giving atropine while the heart is under digitalis would be to accelerate it as much as it would be accelerated by atropine before the digitalis was given, because the effect of atropine is only to paralyze inhibition. If, on the contrary, while the heart is slowed by digitalis, the acceleration produced by atropine paralyzing the inhibition is not as great as it is before the digitalis is administered, then it necessarily follows that digitalis is having some other action besides merely stimulating the vagus and increasing the inhibition tone.

In Cushny's experiments the amount of acceleration produced by atropine while the hearts were slowed by digitalis was not as great by any means as it was in the same hearts before the digitalis was administered. A curious effect becomes apparent by a study of these results, namely, that the slow heart under digitalis is not only not controlled by increased tone of the vagus center, but is actually in a state of diminished repression, because, since the amount of control exercised by the inhibitory center may be estimated by the amount of acceleration following its elimination by atropine, then the fact that a less degree of acceleration follows the use of atropine in the heart under digitalis shows that the heart is that much less controlled. The amount of acceleration under atropine may actually be used to estimate the efficacy of digitalis, because the acceleration lessens with the improvement and increases with the failure of improvement.

There is, then, no other possibility than to assume that inhibition is not involved in the therapeutic effects of digitalis in auricular fibrillation, and the real explanation is found in diminution or depression of the irritability of the conducting system, the sino-auricular node, the node of Tawara, the bundle of His in part or in whole. In strong support of this is the fact that if the digitalis is pushed, partial heart block appears, and heart block is due to no other cause than to a depression of the function of conduction. In the frog, auriculo-ventricular block is often seen following the injection of minimum lethal doses of digitalis. In healthy mammals, however, digitalis block is usually inhibitory, though interference of conduction through the bundle has likewise been observed.

As Cushny states, "another explanation of the slowing in clinical cases of auricular fibrillation might be based on the digitalis substances reducing the excitability of the ventricle," but it seems hardly likely that this occurs to any great extent in man, and it seems difficult to reconcile the view with the known fact that, in the lower animals, digitalis increases the force of the ventricular contractions. *Theoretically, we might assume that digitalis simultaneously depresses the bundle of His and stimulates the contractile fibers of the ventricles.*

In non-fibrillating cases of heart failure digitalis likewise reduces the rate of the heart and relieves the symptoms in a certain

proportion of the cases, but the amount of reduction and the number of cases affected is strikingly less than in fibrillating ones.

In cases with the normal rhythm, if the digitalis be pushed, partial heart block or sinus arrythmia are especially likely to develop. In three out of five cases of cardiopathy with normal rhythm Cushny found that the injection of atropine was followed by disappearance of the slowing and irregularity induced by digitalis, and an acceleration of the pulse rate quite equal to that which had obtained before the use of digitalis, and he therefore concludes that in these cases the slowing induced by digitalis was inhibitory in character. In other cases, however, the slowing and block were unchanged by atropine, and must, therefore, have been due to the direct effect of digitalis upon the bundle, as is the case in fibrillation.

The natural inference to be drawn from all these facts is that the inhibitory stimulation produced by digitalis has nothing to do with the beneficial action of the drug in cases of heart failure, and that the benefits derived are due to direct effects of the drug upon the cardiac muscle itself.

## SUMMARY.

I. Historically considered, it is interesting to note that the lately-discovered fact that digitalis depresses the conductivity of the bundle of His, thus acting upon the heart by lowering one of the important functions, tends to restore the older view that, essentially considered, digitalis is a sedative much more than a stimulant to the heart.

II. Physiologically considered, that is to say, upon healthy animals under the conditions of laboratory experiments, digitalis slows the heart through vagus stimulation, increases the force of the systole, diminishes the extent of diastole, constricts the vessels and raises the blood pressure. A depression of the healthy bundle has not unequivocally been made out.

III. Clinically considered, it is found that beneficial therapeutic effects from digitalis are found almost exclusively in that particular form of cardiopathy which has received the name of auricular fibrillation. In this condition the effects of digitalis are quite marvelous. In auricular fibrillation the bundle of His may be assumed to be in a condition of pathological excitability and irritability, since normal impulse formation is replaced by impulse formation at multiple auricular foci. The action of digitalis in auricular fibrillation is to depress the function of the bundle of His, and thus to reduce both the formation and the transmission of pathologically formed impulses. Vagus stimulation plays no part in the slowing of the heart, except in non-fibrillating cases. Whether or not the force of ventricular contraction is increased is not known. It is not inconceivable that digitalis may produce a simultaneous depression and stimulation of different parts of the cardiac musculature.

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# THE LABORATORY DIAGNOSIS OF SYPHILIS.

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*Mr. President, Ladies and Gentlemen:*

In a disease so protean in its manifestations, so liable to recurrence and so hazardous to pronounce cured in the absence of active symptoms, all of which characterize syphilis, any aid in the establishment of a diagnosis, the rendering of a prognosis or the control of therapy in this condition should form a very tangible part of the practitioner's armamentarium against this disease, martialed by one delegated by him, if not by himself.

It is our purpose to outline very briefly the methods employed in the laboratory for the detection and control of lues and to state in what stage of the disease each has its optimum value.

The microscopic picture of the blood is not, on the whole, very conclusive evidence. There is frequently at the onset of the secondary stage a secondary anaemia, occasionally severe, and perhaps ushered in with alarming rapidity. Indeed, Justice has pointed out that at this stage of the disease the administration of a large dose of mercury so constantly induces a decrease in haemoglobin of from ten per cent. to twenty per cent. in a period of from twelve to twenty-four hours that such a therapeutic test may be profitably made for diagnostic purposes. During the sec-

ondary stage of syphilis there is usually a moderate increase in the leucocytes (15,000 to 18,000), the increase affecting the lymphocytes particularly. The most marked changes occur in the congenital luetic.

A far more important and valuable microscopic finding—indeed, the only pathognomonic evidence from either the clinical or laboratory picture—is the detection of the infecting organism, the Spirochaeta (or more properly Treponema) Pallida. Schaudinn found them in primary, secondary and tertiary morbid processes, while Noguchi has just announced that he has identified them in extraordinary numbers in the brains of general paretics, thus proving their association with the final quartinary or parasyphilitic lesions. Etiologically then, the constant association of this organism and the luetic lesion as cause and effect is established, but for diagnostic purposes, the chancre and a few of the secondary erruptions, notably condyloma, mucous patch and pustule, alone offer great prospects to the clinical microscopist. From such a lesion, however, one may usually obtain some bloody serum, which on examination will show the organism. For this examination the ideal method is by means of the so-called dark field illumination. The apparatus consists of a powerful electric arc as a source of light and a specially constructed sub-stage for the compound microscope, which dark field condenser is substituted for the Abbe's condenser. A drop of the serum is placed on a glass slide, a cover-slip superimposed, a drop of immersion oil placed on this and another on the surface of the uppermost lens of the condenser. The preparation is then examined immediately. The slide is placed in position as usual, the sub-stage so centered and adjusted that the drop of oil on its superior lens also comes in contact with the bottom surface of the slide, while that on the cover-slip engages the oil immersion objective. The light of the electric arc is so directed by the reflecting mirror and the sub-stage so adjusted that active Brunonian movement is observed. By this method not only the morphology of the Treponema is determined, but the added diagnostic point, the manner in which it moves may also be seen. The organism is very slender, usually less than 0.5 of a micron, and of varying length, of from 4 to 15 micra. It is tightly twisted like a cork-screw in from 3 to 30 regular curves whose fineness and regularity are important features in differentiating the pallida from other organisms likely to be encountered. Though provided with flagella, the movements of the pallida are only twisting, bending and rotating.

A far simpler, though less satisfactory, method is to dilute a drop of the serum with an equal quantity of good India ink, cover with a cover-slip and examine with the oil immersion lens of the ordinary microscope. The morphology of the organism stands out in this case as a delicate, colorless spiral in marked contrast to the dense blackness which constitutes the remainder of the field.

Though there are other methods of detecting the Treponema obtained from active lesions, the use of the dark field is by far the most efficacious and the India ink method the simplest.

With the organism the testicle of the rabbit may be innoculated with the production of syphilitic orchitis, which on section and stained with silver nitrate according to Levaditi shows the pallida in situ. This has little diagnostic application.

Within the last couple of years Noguchi has succeeded in growing the palida in vitro, an accomplishment which until then had been attended only with failure. Absolute exclusion of air is essential to the growth of this organism, which condition Noguchi satisfied by placing sterile kidney or other tissue, excepting liver, at the bottom of the culture-tubes and layering the top of the medium with liquid petroleum. The medium itself may be either liquid or solid, though initial extra-corporeal growth is better effected on the solid medium, serum agar-agar than the liquid one, serum water.

With this finding as a basis, Noguchi introduced another diagnostic method, the luetin test. A pure culture of Treponema pallida is killed, intimately mixed with the medium in which it is grown and preserved with a weak solution of phenol or tricresol. This constitutes luetin. The reaction is obtained by injecting 0.03 c.c. of this intracutaneously, preferably on the arm. A control of the same materials minus the organism, in equal quantity, is injected at a corresponding site of the opposite side. The injection is best done with a "Sub-Q" syringe graduated in hundredths of a c. c. Separate syringes should be used for luetin and control and should never be utilized for other purposes. The sterility of both injections should be ascertained before administration. It is important that the injection be *intra*-dural, i. e., between the horny layer and the corium, and that it be given under strictly aseptic conditions. The reaction is local and appears usually about the fifth day, but varies from the second to thirtieth. It consists of a painful erythematous, macular, papular, or pustular area (or any combination of these) surrounding the site of injection. The most usual feature is an indurated red papule the size of a dime. Necrosis and even extensive sloughing, however, may occur. The control may give a decided reaction, particularly in tertiary and congenital cases. Otherwise the test reaction should be decidedly more marked than the control. The mild reactions can properly be interpreted only by those widely experienced with the reaction, while faulty technique may quite belie the true result. Properly administered and interpreted, the following conclusions pointed out by Noguchi seem fairly well established with reference to the luetin reaction:

1. It is specific for syphilis.
2. It is usually present in tertiary, latent, treated secondary and congenital lues.

3. It is less constantly so in primary and untreated secondary cases.

4. It is quite inconstant in the parasyphilitic affections.

5. It is, when once positive, little affected by treatment, except in some cases believed to be permanently cured.

Certain dangers (not the least of which is the danger of transmitting syphilis which has occurred at least twice) and the pain connected with the reaction make it inadvisable as a routine measure. Conservative use of the luetin test, however, overrules these objections under two circumstances: In those cases of suspected latent and tertiary lues, where all other evidence is inconclusive; and in those cases which have formerly been positive to the reaction, and, after radical therapy, have completely cleared up, when a second reaction, if negative, speaks favorably for complete eradication of the disease.

By far the most universally applicable laboratory diagnostic method for the detection of syphilis is the Wassermann reaction. Before attempting a comprehensive definition of the reaction itself it is well to get clearly in mind some rather cumbersome terms essential for an understanding of the rational of the test.

Antigens are substances which, when administered to animals, either by infection or inoculation, are capable of inducing a reaction on the part of that animal, with the production of specific antagonistic substances to the material so administered. Various bacterial products, e. g. diphtheria and tetanus toxines, when injected, are antigens, giving rise to specific antitoxines. Certain albuminous substances, blood-serum, milk, some bacterial extracts, etc., are also antigens, their injection being followed by the production of antagonistic substances. which precipitate the specific protein employed in its production, and are hence called precipitins. Certain bacteria themselves are antigens, giving rise to antagonistic substances, which in the presence of their antigenic organism may either dissolve them or cause them to congregate in masses. Such antagonistic substances are known respectively as bacteriolysins and agglutinins. Finally, certain somatic cells, and in particular the red blood cells of a species alien to the animal to which they are administered, induce antagonistic substances to those specific cells. The antagonistic substance so produced is termed amboceptor, one of the two active principles concerned in the biological cytolysis or dissolution of cells. In the Wassermann reaction the cytolysis is concerned only with red blood cells. Haemolysis being the cytolysis of red blood cells, the amboceptor is hence termed an haemolytic amboceptor. For convenience, future reference to amboceptor will imply hemolytic amboceptor. The specificity of amboceptor is, however, so marked that that induced by sheep's blood differs from that induced by dog's or man's. Hence the term anti prefixed to the species whose red blood cell induced the amboceptor is utilized in designating the specific amboceptor, *e. g.*, antisheep amboceptor,

antihuman amboceptor, etc. The rabbit is the most adaptable laboratory animal for the artificial production of amboceptor by the injection of red blood cells of various animals. Amboceptor is fairly stable and not destroyed readily by heat.

All of the specific antagonistic substances produced by the administration of antigens are known as antibodies. These antibodies are quite specific for the antigen which produced them. They may be inherent in the animal's serum, when they are known as natural antibodies, or they may be produced artificially by single or repeated injections of antigens to a suitable animal, as is done in the production of amboceptor. Finally, they may be induced by the accidental infection of an organism by bacteria. In syphilis the treponema or its products, acting as the specific antigen, produce specific antibodies—syphilitic antibodies.

Complement comprises the other active principle concerned in biological cytolysis. Complement, though normally present in all fresh sera, is not identical with that of species alien to that from which it was derived. It gradually disappears spontaneously from the serum on standing, and is completely changed in its character by heating for half an hour at 56° C. The change so effected is termed inactivation. The addition of unchanged complement to inactivated serum is termed reinactivation. The complement of the guinea-pig is unusually adapted to the reinactivation of alien sera, and is the one of choice in the Wassermann reaction. By the fixation of complement one means that complement has so entered into a firmly bound union with an antigen and an antibody that it is unavailable for use in linking together a second antigen and antibody in which complement is essential for a complete reaction between the two.

A hemolytic system consists of complement, amboceptor and a suspension of the latter's antigenic red blood cells, all strengths of these ingredients being in such proportion that equal volumes of each will just satisfy the requirements of complete hemolysis.

With this explanation of terms, let us attempt a definition of the Wassermann reaction before proceeding to the *modus operandi* of conducting it.

The Wassermann reaction is based upon the fact that during a syphilitic infection certain antibodies are usually elaborated by the infected individual and present in his serum, which antibodies in the presence of certain antigenic lipoid substances have the power of fixing complement. This fixation of complement in whole or in part is determined by the addition of an incomplete hemolytic system consisting of red blood cells and their specific amboceptor. In the event of the syphilitic antibody being absent in the first system the unbound complement is then capable of completing the hemolytic system, in which case hemolysis takes place, whereas if the syphilitic antibody in the first system is present, the complement in whole or in part is fixed, and to that degree is incapable of completing the hemolytic system when hemolysis is inhibited

wholly or partially, as the case may be. Hence hemolysis speaks against the presence of syphilitic antibody, and, therefore, syphilitic infection, while inhibition of hemolysis indicates the contrary.

The ingredients for the performance of the test vary somewhat among different workers, but those following are fairly typical.

*Complement.*—A guinea-pig is bled under anesthesia, the blood cooled, centrifugalized, and the serum first separated from the clot and then diluted to ten times its volume with sterile normal salt solution—the constant diluant for all reagents of the test. Complement should be carefully guarded against exposure to light and elevation of temperature, even those of the room.

*Antigen.*—An extract of the liver of a syphilitic fetus was formerly used, but the active principle of this was found chemically to be composed mainly of lipoid substances. With this as a basis, non-syphilitic tissue has been utilized for the purpose. Beef heart, being particularly rich in these substances, an alcoholic solution of its acetone insoluble fraction is now being widely used. This is diluted to the proper strength at the time of the test.

*Red Blood Cells.*—Blood is sterilly collected, usually either from man or the sheep; defibrinated, centrifugalized and washed thoroughly with salt solution to free entirely from the serum, which contains complement or other interfering bodies. The washed corpuscles are used as a weak suspension in sterile salt solution.

*Amboceptor.*—By the repeated inoculation into a rabbit of either human or sheep erythrocytes the rabbit reacts with the formation of specific hemolytic antihuman or antisheep amboceptor, as the case may be. When these antibodies are in sufficient concentration in the serum of the animal it is killed, the blood collected sterilly and centrifugalized. The serum is placed in small glass beads, which are hermetically sealed; the serum then inactivated by heat, and finally stored away in a cool, dark place until required for a test, when one of the tubes is broken and the serum diluted to the desired strength. Naturally, when using human erythrocytes, antihuman amboceptor must be employed, and for sheep red blood cells antisheep amboceptor is required.

*Syphilitic Antibody.*—The only ingredient of all reagents unknown may or may not be present in the patient examined. A quantity of blood (2 or 3 c. c. is desirable) is obtained from the patient either by pricking the ear or by venipuncture. The clot is allowed to form and the blood-free serum alone is utilized.

The Wassermann reaction is not merely a qualitative, but a more or less quantitative determination. Hence the various known ingredients must be in predetermined strengths, *i. e.*, of known titre. We employ constantly a uniform dilution of washed blood corpuscles—for example, a 5 per cent. suspension. Likewise we use a constant dilution of complement—1 in 10. We determine upon a constant quantity of each of these substances to be used—say, 0.5 c. c. We must then determine the maximum dilution of amboceptor necessary to effect complete hemolysis

when the volume of the diluted amboceptor is also 0.5 c. c. Let us designate this amount of amboceptor in this dilution as x amboceptor units.

Since within certain limits the quantitative relationship existing between amboceptor and complement is constant, we may say that in the hemolytic system so constructed there are also x complement units, and, furthermore, since all of the cells of the erythrocyte suspension were laked and all of the x amboceptor and complement units were utilized in accomplishing this, there are also x red blood cell units. Such a hemolytic system is said to be complete, while any ingredient less than this (say having but y units) will leave unsatisfied the bonds of (x — y) units of the remaining ingredients, and to that extent the hemolytic system is incomplete.

In the same way that we construct a quantitative hemolytic system we can build up certain other quantitative antigen-complement—antibody systems. For instance, we may use x units of syphilitic antigen (this strength may be obtained by titration), add x units of complement as was done in the hemolytic system, and from a luetics serum add x units of syphilitic antibody. In such a system all of the unsatisfied bonds of the x units of the three ingredients would be mutually satisfied, the system would be complete, all the complement would be fixed. If, however, keeping the antigen and complement constant at x units, and adding but y units of antibody (y being less than x), then but y units of complement would be fixed, leaving (x — y) units of complement free to enter into any other antigen-antibody combination which might be subsequently added.

Insomuch as a syphilitic system so constructed yields no visible reaction, a circuitous method is utilized in determining the degree of complement fixation in it. To a syphilitic system whose completeness with reference to antibody is unknown a complement-free hemolytic system is added as an indicator. The degree of hemolysis resulting (a visible and roughly measurable phenomenon) is an inverse index of the extent of complement fixation that occurred in the syphilitic system. This, in turn, is a direct index of the syphilitic antibody content in the patient's serum.

Obviously, under these conditions, the arbitrarily chosen x used to designate the number of units of these various reagents must be numerically so high that only those with a maximum syphilitic antibody content should possess x units of it in the arbitrarily chosen quantity of serum. On the other hand, y is a variable, ranging from x to 0, and corresponds in all cases to the number of syphilitic antibody units in the tested serum.

The actual performance of the test may be carried out as follows: For each series of tests a known syphilitic and a known non-syphilitic serum is carried through the process as controls. These and the serum of each specimen are inactivated by heating in a water bath at 56° C. for half an hour. In the event of using

an antisheep hemolytic system it is advisable to dilute the inactivated serum with the sheep red blood cell suspension and to incubate the whole for half an hour in a water bath at 37° C. to free the serum from any natural antisheep amboceptor which might be present. Thereafter the diluted serum is centrifugalized and the clear supernatant fluid alone used. In an antihuman system the serum is diluted with salt solution. In either event equal quantities (0.5 c. c. is a convenient volume) of the diluted serum are placed in each of two test-tubes arranged in front and rear rows in a double row test-tube rack. In both tubes place also 0.5 c. c. of diluted complement (each containing x units). To the rear row add 0.5 c. c. of diluted antigen (also containing x units), while to the front row, which is used as a control for peculiarities of the serum, 0.5 c. c. of salt solution (containing 0 units of antigen) is substituted. Both tubes are then incubated in a water bath at 37°C for thirty minutes to facilitate the interaction between antibody (if present) complement and antigen. Following this 0.5 c. c. of the red blood cell suspension (x units) and 0.5 c. c. of diluted amboceptor are added to each tube. In the case of amboceptor 2½ to 3 x units are added. The reason for this is manifold, but chiefly to offset the dilution of complement necessitated by the addition of 0.5 c. c. of both serum and antigen and to counteract any substances in these which may be antagonistic to complement. Furthermore, this gives the patient the benefit of all reasonable doubt on the negative phase of the reaction. The tubes are again incubated in the water-bath at 37°C., this time until the control tube is completely hemolyzed. The result of the reaction is then determined, both test and control being compared with especial reference to the intensity of the red color of the supernatant fluid and the quantity of red cells at the bottom of the tube.

Through the extent of hemolysis is often placed in percentage values, this cannot be done with accuracy. A more feasible method is to rate the results of the test as (-), (±), (∓), (+), (++) and (+++), the grades of hemolysis being complete, nearly complete, a little more than half complete, a little less than half complete, slight, and nil, respectively, in accordance with the degree of complement fixation as y antibody units in the syphilite system increases from 0 to x. Judging by the test alone, for diagnostic purposes (++) and (+++) are definitely indicated of active lues, (—) and (±) definitely against it, (∓) and (+) are doubtful. The validity of such a diagnosis is not ultimate, however, as the clinical aspect is of no little importance. The following suggestions should guide the clinician in his interpretation of the laboratory findings: The significance of a negative reaction in the primary stage is nil. About 80 per cent. of secondary untreated lues yield (+++) reactions, about 15 per cent. (+) or (++), while about 5 per cent. do not develop a positive phase at all. The in-

tensity of the reaction diminishes as treatment becomes effectual and the actute stage subsides. In tertiary lues the percentage of results, contrary to clinical evidence, rises to about 15 per cent., the remainder tending not to show as intense reactions, few yielding a (+++). In latent lues a (+++) is even less often obtained, a (+) is diagnostic, and even a (∓) is suggestive. In general paresis most yield a (+++), while in tabes this drops to 50 per cent. to 60 per cent.

When the clinical evidence and the Wassermann are not in accord, the test should be repeated at three-month intervals for a year, if necessary. The decrease in the degree of complement fixation, as determined by repeated Wassermann reactions at about three-month intervals, is of inestimable value in the control of therapy. A single negative reaction is, however, not sufficient evidence to warrant discontinuance of treatment, though the absence of all clinical evidence of the disease and repeated negative Wassermann's at three-month intervals for a year does justify the withdrawal of treatment, though not necessarily the ultimate cure of the disease. A luetin test in this instance may throw much light upon that mooted point.

It should be borne in mind that untreated lues, or lues without treatment for a considerable period, though the Wassermann is negative, may, upon the administration of anti-luetic treatment, and for a variable time thereafter, yield a positive Wassermann. This phenomenon is known as a provocative Wassermann reaction.

A final word upon the behavior of the cerebro-spinal fluid in syphilis of the central nervous system, including tabes and general paresis. In these conditions the number of white cells, usually small lymphocytes, is materially increased, to as high as 150, instead of three or four. The protein content, particularly the globulin, is likewise increased, even in excess of that due to the cellular augmentation. Finally,. the Wassermann test, using the spinal fluid instead of the blood serum, usually yields a positive reaction in an active process, even though the test with the blood was negative.

In conclusion, the blood picture, the detection of the treponema pallida, the production of luetic lesions in animals with this organism, its cultivation in vitro, the luetin and Wassermann reactions, and the tests with the spinal fluid in lues of the brain and cord, afford a laboratory array of diagnostic and prognostic measures which the clinician can ill afford not to employ in this class of cases.

1902 Eastern Avenue.

# NEWER METHODS IN GASTRO-INTESTINAL DIAGNOSIS.

*By Dr. Ernest H. Gaither.*

In recent years many new diagnostic methods in different fields of medicine have been described—some of true value, others of indifferent caliber, while still others have not withstood the test of experience. In company with these wonderful strides, methods of diagnostic value, with especial reference to the gastro-intestinal tract, have made their appearance until at present we are very fortunate in possessing truly valuable adjuncts to our previous knowledge concerning this important branch of internal medicine.

It obviously would be an impossible task to endeavor in the short space of time allotted to attempt to bring to your attention even in the most superficial manner all or nearly all of the laboratory methods available, so will be content to direct your attention in a very brief manner to what seems to be the most important of the newer methods in gastro-intestinal diagnosis, with a few exceptions, treating the matter wholly from a laboratory point of view.

Two methods have been lately brought forward for the determination of the motoric power of the stomach—one, "The Water Soluble Chloraphyl Test," by Boas; the other, "The Starch Retention Test," by T. Hausmann.

The procedure in the former is carried out as follows: To 400 c. c. of water 20 drops of water soluble chlorophyl are added, and this taken on an empty stomach. The fluid is aspirated from the stomach in half hour, at which time under normal conditions 50 to 60 c. c. of green colored fluid should be found. If more, then motor insufficiency should be assumed. Mucus or saliva should not be swallowed while the water is in the stomach on account of the liability of the chlorophyl to collect upon it.

The reasons advanced for using water as a means of motoric power determination are that it does not stimulate gastric secretion and thus has no reflex action on the pylorus; the balance remaining in the stomach after a given interval is readily determined and there is no sedimentation to interfere with the findings. Boas also claims this test to be a convenient method in order to show whether or not conditions are improving under treatment.

"The Starch Retention Test," by T. Hausmann. This author admits that the finding of currants twelve hours after the test supper indicates a motor insufficiency of the stomach, but contends that this disturbance may be due to a mechanical interference or atony of the stomach walls, whereas the discovery of microscopical particles of starch speaks certainly for obstruction of a mechanical nature. This statement is made, he says, only after a

very extensive experience during 10 years of close observation. The test is carried out as follows:

Twelve hours after a test supper of boiled rice (small plateful) the fasting stomach is aspirated, the contents are set aside, preferably in a sedimentation glass, for about five minutes. The supernatant fluid is then poured off and a few drops of Lugol's solution or preferably tincture iodine are added, and then thoroughly mixed with the residue; now dilute with water until the mixture is transparent. If rice particles are present, they will appear as dark blue granules throughout the fluid, floating on top or gravitating to the bottom. Hausmann also states that the discovery of starch by microscopical means only speaks merely for an atonic condition, and has never encountered a case of macroscopical retention which proved to be atony alone.

Another point emphasized is that currants are not always recovered when the stomach contents are aspirated, even when present, and, therefore, that method is not as trustworthy as the one just described. His patients are aspirated in the prone position. Experience with both tests points to the greater reliability and accuracy of the Hausmann starch retention test, which has been used rutinely in the gastro-intestinal division of the Johns Hopkins dispensary for the past six months on a large number of patients, and thus far bears out the observations of Hausmann in every particular. This method is simpler in its performance, and much more convenient for the patient; for in this test aspiration is practiced but once, while in the chlorophyl method aspiration is made use of twice—before and after the intake of the colored solution; then, again, it seems that the reliability of the latter test might to a certain extent be interfered with by the possibility of some remaining fluid in the stomach, which would serve to change the color of the fluid. It must also be remembered that the coloring matter collects on all mucus or saliva that is swallowed, thus again interfering with the color reaction. So, for these reasons, it seems that the Hausmann test is more reliable and much to be preferred to that of Boas.

*Pancreas.*—Of late much interest has been manifested as regards investigations looking toward the diagnosis of pancreatic diseases of which much is unknown, but at present we possess methods which give promise of being great aids in this hitherto unsatisfactory field. The ones which seem capable of bearing out our assertions are T. R. Brown's modifications of Wohlgemuth's methods for diastase estimation in urine and feces and the casein test for trypsin by Fuld.

The estimation of diastase in urine is as follows:

A twenty-four-hour specimen of urine under toluol is diluted to a certain point, and this placed in a series of test tubes in gradually diminishing amounts, after which solutions of normal salt and soluble starch are added; then placed in water bath 37.5° to 38° c. for 30 minutes, removed, water added and decinormal iodine

solution added. A note is made of first change between blue, showing undigested starch, and red, showing erythrodextrin starch digestion.

Determination of diastase in feces: An enema night before if necessary. At 8 A. M. slice of bread, glass of milk; 8.30 and 9 A. M., salts given; save stool until 1 P. M. and weigh. Dilute stool; put in gradually diminishing amounts in a series of test tubes mixed with normal salt, after which soluble starch solution is added. After one-half hour in bath at 37.5° to 38°, remove and add decinormal iodine solution. Same reaction noted as in urine test.

*Trypsin Test.*—Stool diluted; thoroughly mixed with salt solution and placed in test tubes in gradually diminishing amounts. A solution of casein, decinormal sodium hydroxide and aqua are added to each tube. Place in bath at 37.5° to 38° for half hour; remove and add a few drops of a solution of glacial acetic acid, alcohol and water.

In the presence of tryptic digestion no reaction is noted. A whitish precipitate shows absence of trypsin.

As to the practical application of these tests, one seems justified in saying that the diastase test for feces and the casein trypsin test are much more reliable and accurate than the diastatic estimation of the urine. It appears that this latter point might be made clear when we stop to consider the many factors and conditions which play important roles before the diastate is eliminated in the kidney secretion.

The elimination of the pancreatic secretion by way of the intestinal canal is, of course, much simpler and more direct and less liable to the complicated chemical and metabolic influences, which we believe invalidate to a certain extent the importance of diastatic determination in the urine. The results obtained in estimating the functional or organic affections of the pancreas, from observance of the diastase and trypsin in the feces, has thus far been very illuminating and quite accurate.

## GASTRIC CARCINOMA.

As to laboratory methods made use of and brought forward of late for the detection of carcinoma, one has only to glance at the formidable array as adduced by various authors in order to discern our great weakness and inability in this direction. However, we should not be deterred in our efforts to solve the problem of an early diagnosis in this perplexing and terrible scourge. The test to which your attention is directed at this time is the Wolff-Junghann soluble albumen test. The test follows:

Filtered gastric contents placed in six test tubes in gradually diminishing amounts and distilled water added until the dilutions range from 1:10 to 1:400. Reverse tubes once or twice and float a solution of phosphotungstic acid, hydrochloric acid, alcohol and distilled water upon the fluid in each tube. A white albuminous ring up to and including the 1:100 dilution speaks neither for nor

against carcinoma; below this point is negative, above is positive.

One requisite of this test is that the gastric contents must contain no free hydrochloric.

This test is based on the assumption that in carcinomatous gastric contents there is an increase of soluble albuminous material, probably due to one of three factors:

(1) That there is a ferment secreted by the cancer cells capable of breaking the proteids down to a further and much simpler point than the normal gastric juice.

(2) Possibly some interference with resorption.

(3) There may be an albuminous secretion from the cancer cells themselves, the so-called "cancer milk."

From personal experience both here and abroad this test is worthy of recommendation and trial because of its simplicity and reliability. After many experiments with it in different varieties of malignant and non-malignant achylias, only once has the finding been contrary to proven clinical conclusions. This was a case of carcinoma at the junction of the esophagus with the cardia; otherwise, cases of a malignant character have been positive, those of a benign nature negative.

### TESTS FOR GLANDULAR SECRETION.

Two excellent tests for the estimation of gastric glandular activity are the Edestin test for pepsin, by Fuld, and Sjoquist's method for the qualitative estimation of combined hydrochloric.

*Edestin Test.*—Filtered gastric contents, thoroughly mixed with a solution of hydrochloric acid having an acidity of 30, are placed in test tubes in diminishing amounts. Then a solution of Edestin made with a solution of hydrochloric acid having an acidity of 30 is added to each tube. After a half-hour bath at 37.5° to 38° c., 1 to 2 c. c. of a saturated sodium chloride solution are added; a white precipitate shows absence of pepsin; no precipitate shows pepsin to be present.

*Sjoquist's Test.*—Ten c. c. of filtered gastric contents placed in crucible, barium carbonate added, reduced to ash, when warm distilled water is added and filtered to clarify. A few drops of a dilute solution of $H_2$ $SO_4$ added. A precipitate shows the presence of combined hydrochloric acid; no precipitate, an absence. The practical value of these tests is the helpfulness in establishing the presence or absence of true grandular affection, especially in cases of achylia, where we are endeavoring to prove the existence or non-existence of an organic disease of the glands themselves. These tests serve to round out and illuminate the clinical picture and objective findings in true organic or functional disturbances.

*Liver Functional Tests.*—Of late the liver functional tests have engrossed the attention of internists more than previously, and a great deal of work has been done along this line. The first to be described is the aldehyde test, which has for its purpose the

determination of the presence or absence of urobilinogen in the urine. The reagent used is as follows:

℞ Paradimethylaminobenzaldehyde, gm. 4.
Hydrochloric acid, gm. 4.
Water and a few drops of alcohol to 200 c. c.

To 5 c. c. of urine a few drops of the above reagent is added. When in the presence of urobilinogen a rose-red color appears at once or in a few minutes, exceptionally though the reaction may be delayed as long as a few hours before the maximum intensity of the color is reached. An excellent method for bringing out the reaction is the addition of a few c. c. of chloroform to the urine reagent mixture, which carries the red color to the bottom of the tube, making a very pretty contrast. Chase gives two reasons for the appearance of urobilinogen in the urine:

(1) Impaired liver cells which have failed to stop or transform the urobilinogen coming to them through the portal vein from the bowels, and which allows its entrance into the general circulation.

(2) Congestive circulatory influences by which the urobilinogen laden blood normally passing through the liver is deflected into the collateral circulation of the portal system as through the hemorrhoidal veins to the iliac veins in constipation or to the general circulation through a caput medusae in advanced cirrhosis.

It is known that—1. Normal liver cells never let an appreciable quantity of urobilinogen pass into the blood of the general circulation. 2. A very slight loss of normal liver function even in a part of the liver is followed by the appearance of a pathological amount of urobilinogen in the urine.

A positive test does not necessarily speak for a grave diseased condition of the liver, but simply points to a deficiency in the functional capacity of the liver cells. Inasmuch as slight positive reactions appear in constipated conditions, it is always advisable to precede the test with a purge. Very often a pinkish tinge is noted, but the test is only positive in the presence of a rose-red color.

*Galactose Test.*—Bauer of Vienna first called attention to this test, which is performed as follows:

Forty gm. of galactose are given in tea on an empty stomach in the morning, after free purgation the night before. The urine is examined by Fehling's method four hours after the intake of the galactose, when under normal conditions no sugar should be present. Where diseased liver conditions are present the elimination is quite large until the sixth hour, and may even be detected up to the tenth to fourteenth hour after the administration of the galactose. Allowances should, of course, be made where gastric conditions are present which would interfere with the propulsion of the stomach contents into the intestine.

The urobilinogen test is one used to detect localized diseased conditions of the liver cells, while the galactose test is one used to discover general pathological conditions of the organ. The latter test is recommended as being especially useful in the diagnosis of

alcoholic cirrhosis; also in septic conditions of infectious diseases with liver complications.

Personal experience with these tests and information gained from others thus far has been disappointing and unyielding in shedding much light upon liver conditions, both local and general. In view of the complex and varied processes through which any substance must pass before being eliminated by the liver, it does not appear that these methods promise a great deal in proving to be truly helpful in the great majority of liver affections.

*Occult Blood.*—The last test to be brought to your attention is the tolidin or orthotolidin test as described by Ruttan and Hardisty for the detection of occult blood. Tolidin or orthotolidin is a crystalline basic body, closely allied to toluidin and benzidin. It is used to detect blood in a watery solution. These authors claim it to be more satisfactory than benzidin on account of its greater delicacy, its more lasting color and the fact that it can be made into a solution that retains its power of reaction for three or four weeks; also that in the presence of very minute quantities of blood the reaction increases gradually in intensity and persists longer than with the other reagents, the color lasting several hours. The method is as follows: Pea-sized piece of feces, mixed thoroughly with about 5 c. c. water; boil in order to destroy oxidizing ferments. Add from 10 to 15 drops of a glacial acetic acid solution of tolidin (1 to 25) to a few c. c. of hydrogen peroxide. Add several drops of the feces solution to the peroxide-tolidin mixture and a green color appears in the presence of blood.

For the same reasons as advanced by the authors of this test and enumerated above, personal experience with this method proves it to be extremely reliable. The fact that it does not have to be made fresh each time it is used, and can be kept for three to four weeks; that it is used to detect blood in a watery solution instead of an ethereal extract, also that the color reaction lasts for a much greater length of time, stamps it as a most desirable method to use.

The Latrobe, Charles and Read streets.

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# ON THE REPORTING OF COMMUNICABLE DISEASES.

*By C. W. G. Rohrer, M.D.,*
Maryland State Department of Health.

(*Continued from August Number.*)

PRINCE GEORGE'S COUNTY.

Area in square miles, 479.6.
Population, 36,147.

Dr. John E. Sansbury, County Health Officer.
Dr. W. F. Taylor, Health Officer of Laurel.
Dr. J. C. Ohlendorf, Health Officer of Mount Rainier.

The infectious disease returns from Prince George's county are classified as "good," totaling 185 for the year 1912.

COMMUNICABLE DISEASE CASES REPORTED IN PRINCE GEORGE COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | 5 | 1 | 3 | .. | .. | .. | 1 | 10 | 9 | 2 | 4 | .. | 35 |
| Scarlet fever | .. | 3 | 3 | 1 | 1 | .. | 4 | .. | .. | 1 | 5 | 2 | 20 |
| Diphtheria | 2 | 3 | 1 | 4 | 4 | 1 | 1 | .. | 5 | 2 | 6 | 2 | 31 |
| Whooping cough | .. | .. | 10 | 15 | 18 | 12 | .. | 1 | .. | .. | .. | .. | 56 |
| Measles | .. | 1 | 2 | 3 | .. | 6 | .. | .. | .. | .. | .. | .. | 12 |
| Chicken-pox | .. | 1 | .. | .. | .. | 1 | .. | .. | .. | .. | .. | 1 | 3 |
| Mumps | 4 | 1 | 3 | 5 | 2 | 4 | .. | 1 | .. | .. | .. | .. | 20 |
| Influenza | 4 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 4 |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Erysipelas | .. | .. | .. | .. | .. | .. | .. | .. | 2 | .. | .. | .. | 2 |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | 2 | .. | .. | .. | .. | 2 |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | 15 | 10 | 22 | 28 | 25 | 24 | 6 | 14 | 16 | 5 | 15 | 5 | 185 |

## QUEEN ANNE'S COUNTY.

Area in square miles, 363.4.
Population, 16,839.

Dr. A. E. Landers, County Health Officer.

The infectious disease returns from Queen Anne's county are classified as "bad," totaling but 69 for the year 1912.

COMMUNICABLE DISEASE CASES REPORTED IN QUEEN ANNE'S COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | .. | .. | .. | 1 | .. | .. | .. | 2 | 12 | 7 | 12 | 3 | 37 |
| Scarlet fever | .. | 1 | .. | .. | .. | .. | 1 | 1 | .. | .. | 2 | .. | 5 |
| Diphtheria | 2 | 1 | 1 | .. | .. | .. | .. | .. | .. | .. | 13 | 4 | 21 |
| Whooping cough | .. | .. | .. | .. | .. | 2 | .. | .. | .. | .. | .. | .. | 2 |
| Measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Chicken-pox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Mumps | .. | .. | .. | 3 | .. | .. | .. | .. | .. | .. | 1 | .. | 4 |
| Influenza | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Erysipelas | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | 2 | 2 | 1 | 4 | .. | 2 | 1 | 3 | 12 | 7 | 28 | 7 | 69 |

## Somerset County.

Area in square miles, 328.6.
Population, 26,455.

Dr. T. Jacob Smith, County Health Officer.
Dr. C. E. Collins, Health Officer of Crisfield.

The infectious disease returns from Somerset county are classified as "good," totaling 127 for the year 1912.

COMMUNICABLE DISEASE CASES REPORTED IN SOMERSET COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | 5 | .. | .. | .. | .. | 4 | 17 | 17 | 4 | 16 | 15 | 3 | 81 |
| Scarlet fever | 10 | .. | 1 | .. | .. | .. | .. | .. | .. | 4 | 1 | .. | 16 |
| Diphtheria | 1 | .. | .. | .. | 3 | .. | .. | .. | 1 | 2 | .. | 4 | 11 |
| Whooping cough | 2 | .. | .. | 5 | .. | 2 | . | .. | .. | .. | 2 | .. | 11 |
| Measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Chicken-pox | 1 | 3 | .. | .. | .. | .. | .. | .. | .. | .. | 1 | 2 | 7 |
| Mumps | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Influenza | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | 1 |
| Erysipelas | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | . | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | 19 | 3 | 1 | 5 | 3 | 6 | 17 | 17 | 5 | 22 | 19 | 10 | 127 |

## St. Mary's County.

Area in square miles, 369.1.
Population, 17,030.

Dr. F. F. Greenwell, County Health Officer.

The infectious disease returns from St. Mary's county are classified as "very bad," totaling but 13 for the entire year of 1912.

COMMUNICABLE DISEASE CASES REPORTED IN ST. MARY'S COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Scarlet fever | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Diphtheria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 2 | 11 | 13 |
| Whooping cough | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Chicken-pox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Mumps | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Influenza | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Erysipelas | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Pellagra | .. | .. | .. | . | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 2 | 11 | 13 |

## TALBOT COUNTY.

Area in square miles, 267.1.
Population, 19,620.

Dr. E. R. Trippe, County Health Officer.
Dr. J. B. Merritt, Health Officer of Easton.

The infectious disease returns from Talbot county are classified as "bad," totaling but 78 for the year 1912.

COMMUNICABLE DISEASE CASES REPORTED IN TALBOT COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | 2 | .. | 1 | .. | .. | .. | .. | 12 | 5 | 12 | .. | 10 | 42 |
| Scarlet fever | .. | .. | 1 | .. | .. | .. | .. | .. | .. | 1 | .. | .. | 2 |
| Diphtheria | 4 | 4 | .. | .. | .. | .. | .. | .. | 2 | 11 | 4 | .. | 25 |
| Whooping cough | 3 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 4 | 7 |
| Measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Chicken-pox | .. | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | 2 |
| Mumps | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Influenza | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Erysipelas | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | 9 | 5 | 2 | .. | .. | .. | .. | 12 | 7 | 24 | 4 | 15 | 78 |

## WASHINGTON COUNTY.

Area in square miles, 457.3.
Population, 49,567.

Dr. W. D. Campbell, County Health Officer.
Dr. H. E. Tabler, Health Officer of Hancock.

The infectious disease returns from Washington county are classified, along with Allegany county, as "very good," totaling 807 for the year 1912. These are the only two counties in the entire State of Maryland which are entitled to this classification. I feel like taking off my hat to Dr. J. E. Pitsnogle, the retired health officer, because he is the Moses that led the people of Washington county through the wilderness of chaotic public health conditions into the promised land of efficient and well-organized methods of sanitation. He is a man of good, sound, practical ideas and sufficient energy and backbone to mold them into action.

Dr. Campbell, the present incumbent, has proven himself to be a most excellent official, and is largely upholding Dr. Pitsnogle's traditions.

The infectious disease returns from Hancock are not what they ought to be.

COMMUNICABLE DISEASE CASES REPORTED IN WASHINGTON COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | 2 | 1 | .. | 1 | 4 | 2 | 4 | 6 | 17 | 25 | 9 | 19 | 90 |
| Scarlet fever | 4 | 7 | 4 | 4 | 1 | .. | 3 | 5 | 5 | 18 | 18 | 18 | 87 |
| Diphtheria | 7 | 10 | 7 | 9 | 6 | 6 | 1 | 6 | 11 | 15 | 23 | 19 | 120 |
| Whooping-cough | 1 | .. | 1 | 2 | .. | 6 | .. | .. | .. | .. | .. | .. | 10 |
| Measles | 11 | 90 | 117 | 100 | 65 | 15 | 1 | 1 | .. | 2 | 29 | 21 | 452 |
| Chicken-pox | 4 | 5 | 2 | 6 | .. | .. | 1 | .. | .. | 5 | 14 | 6 | 43 |
| Mumps | .. | .. | .. | 1 | .. | .. | .. | .. | .. | .. | .. | .. | 1 |
| Influenza | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | 1 |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Erysipelas | .. | .. | 1 | .. | .. | 1 | .. | .. | .. | .. | .. | .. | 2 |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | 1 |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | 29 | 113 | 132 | 123 | 76 | 30 | 10 | 18 | 35 | 65 | 93 | 83 | 807 |

## Wicomico County.

Area in square miles, 368.9.
Population, 26,815.

Dr. Charles R. Truitt, County Health Officer.

The infectious disease returns from Wicomico county are classified, along with Charles, Garrett and St. Mary's, as "very bad," totaling but 44 for the entire year of 1912.

COMMUNICABLE DISEASE CASES REPORTED IN WICOMICO COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | .. | .. | .. | .. | 1 | .. | 23 | .. | 3 | 8 | .. | .. | 35 |
| Scarlet fever | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 | .. | .. | 1 |
| Diphtheria | .. | .. | 1 | .. | .. | .. | .. | 1 | .. | 4 | .. | .. | 6 |
| Whooping cough | .. | .. | .. | .. | .. | .. | .. | 1 | .. | 1 | .. | .. | 2 |
| Measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Chicken-pox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Mumps | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Influenza | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Erysipelas | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Pellagra | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Total | .. | .. | 1 | .. | 1 | .. | 23 | 2 | 3 | 14 | .. | .. | 44 |

## Worcester County.

Area in square miles, 491.5.
Population, 21,841.

Dr. Paul Jones, County Health Officer.
Dr. R. Lee Hall, Health Officer of Pocomoke City.

The infectious disease returns from Worcester county are classified as "good," totaling 108 for the year 1912.

COMMUNICABLE DISEASE CASES REPORTED IN WORCESTER COUNTY, YEAR OF 1912.

| Name of Disease. | January. | February. | March. | April. | May. | June. | July. | August. | September. | October. | November. | December. | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Typhoid fever | 1 | 3 | .. | 1 | 12 | .. | 11 | 7 | 13 | 10 | .. | 3 | 51 |
| Scarlet fever | 4 | 1 | 12 | .. | 12 | .. | .. | .. | 1 | .. | .. | .. | 20 |
| Diphtheria | 4 | 4 | .. | 1 | .. | 1 | .. | .. | 3 | .. | .. | 1 | 14 |
| Whooping cough | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 2 | 2 |
| Measles | .. | .. | .. | .. | 3 | .. | .. | .. | .. | .. | .. | .. | 3 |
| Chicken-pox | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Mumps | 3 | 4 | 1 | 2 | .. | 3 | .. | .. | .. | .. | .. | .. | 13 |
| Influenza | 2 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 2 |
| German measles | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Smallpox | .. | .. | . | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Malaria | .. | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | 1 |
| Meningitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Erysipelas | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 |
| Anterior poliomyelitis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Septicemia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Acute dysentery | .. | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | 1 |
| Total | 15 | 12 | 13 | 4 | 7 | 4 | 11 | 9 | 17 | 10 | .. | 6 | 108 |

The following table will give a condensed summary of the status of the 23 counties of Maryland in regard to the reporting of communicable diseases:

STATUS OF THE COUNTIES OF MARYLAND, COMMUNICABLE DISEASE REPORTS, 1912.

| Comparative rank. | Name of County. | No. of cases reported. | Classification. |
|---|---|---|---|
| 1st | Allegany county | 1567 | "Very good." |
| 2d | Baltimore county | 961 | "Good." |
| 3d | Washington county | 807 | "Very good." |
| 4th | Frederick county | 364 | "Good." |
| 5th | Carroll county | 277 | "Good." |
| 6th | Anne Arundel county | 222 | "Good." |
| 7th | Dorchester county | 186 | "Good." |
| 8th | Prince George's county | 185 | "Good." |
| 9th | Montgomery county | 144 | "Good." |
| 10th | Somerset county | 127 | "Good." |
| 11th | Howard county | 110 | "Good." |
| 12th | Worcester county | 108 | "Good." |
| 13th | Cecil county | 98 | "Good." |
| 14th | Talbot county | 78 | "Bad." |
| 15th | Caroline county | 76 | "Bad." |
| 16th | Kent county | 74 | "Bad." |
| 17th | Harford county | 74 | "Bad." |
| 18th | Calvert county | 71 | "Bad." |
| 19th | Queen Anne's county | 69 | "Bad." |
| 20th | Charles county | 47 | "Very bad." |
| 21st | Wicomico county | 44 | "Very bad." |
| 22d | Garrett county | 23 | "Very bad." |
| 23d | St. Mary's county | 13 | "Very bad." |

*(To be continued in October.)*

# MARYLAND MEDICAL JOURNAL

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BALTIMORE, SEPTEMBER, 1913

## THE QUARANTINE QUESTION.

THE transfer of the Baltimore Quarantine Station to the Federal Government has now been under discussion for several months. Much progress has been made in this movement despite the fact of opposition from certain quarters. All the arguments in favor of a national quarantine service at this port are plain, common-sense arguments.

Following the discussion of this question before the Baltimore City Medical Society, the Board of Directors of the Chamber of Commerce passed resolutions opposing the transfer, on the grounds that such action would prove injurious to the best maritime interests of the port. While we do not doubt the sincerity of this belief, we do fail to see that it is a logical argument in favor of the retention of the station by the city.

The medical fraternity of the city is practically unanimously in favor of Government ownership of the quarantine, and a number of organizations have gone on record as favoring the transfer to the Federal authorities, chief among these being the City-Wide Congress, the Park Approach Protective Association, and recently the Merchants and Manufacturers' Association came out strongly in favor of the transfer.

At the present writing the shipping interests of the port have so far relented from their first opposition, which was made manifest through the declaration of the Chamber of Commerce, as to now favor this action, provided the ports of Boston and New York will agree to make the same changes in their service at the same time. This is a move in the right direction, but whether it will be possible to carry out this proposition remains to be seen. Both New York and Boston are, as far as the public is concerned, in favor of Government ownership of their quarantine stations, but the same selfish reasons for municipal retention are claimed in those cities as exist in Baltimore.

Some one of the three aforesaid cities, whose quarantine stations have not yet come under Federal control, must first make the move in this matter, and why not Baltimore.

As is admitted on all sides it is but a matter of time until the quarantine stations of all the ports in this country will be in the hands of the Government. And why should Baltimore not be the first to make the move, rather than to wait until she may be forced, in the face of some threatened crisis, to take such action?

---

## THE PRESENT OUTBREAK OF TYPHOID FEVER IN BALTIMORE.

For some unusual reason the city of Baltimore is this summer in the throes of a severe typhoid epidemic. Since the method of conveyance of this disease is thoroughly understood, this should not be. Formerly typhoid was thought to be entirely water-borne, but it is now recognized that the fly is a very effective agent in the transmissal of the affection. With the exception of those accidentally infected while handling typhoid patients, the above-mentioned avenues are the principal paths in the spread of the malady. Watered milk or infected food occasionally serve as the infecting agent. What lesson has been taught by the above facts? It is that typhoid fever is an unnecessary affliction, as both its method of conveyance and its cause are thoroughly known. Typhoid germs cannot withstand heat, therefore, if the water be boiled, the possibility of being taken down with this affliction is materially lessened, and still more so if flies are kept away from typhoid contaminated ejecta. Filtration of the water supply of cities has also played its role in the reduction of enteric fever. As Baltimore has no filtration plant, her citizens, if they wish to avoid the possibility of contracting typhoid, must resort to the aforementioned preventive measures. These, however, are troublesome, consequently likely to be neglected. This being so, science has given to the world a practical method of preventing typhoid. When the technic is perfect, it is absolutely devoid of dangers. We know that occasionally disagreeable symptoms occur as the result of its administration, but these are only temporary. We are speaking of immunization by the injection of the so-called typhoid vaccine. The fate of the American Army during the Spanish-American War is known, likewise that of the maneuver camp at Galveston, the one ravaged by typhoid, the other free. Physicians, advise your patients to take the vaccine before it is too late.

# REPORT OF BOARD OF MEDICAL EXAMINERS OF MARYLAND.

## QUESTIONS AT THE JUNE (1913) EXAMINATIONS.

### CHEMISTRY.

1. Distinguish between "chemical" and "physical" changes in matter and give an example of each.

2. (a) Define an acid. (b) Give formula of one inorganic acid and show how this formula fulfills the conditions stated in your definition. (c) Give the name and formula of one organic acid.

3. (a) Should a physician order iodide of potash and corrosive sublimate in the same solution, what chemical and physical changes would take place in the mixture? (b) Would the resulting products be harmful to the patient and, if so, which?

4. Complete the following equations:

$$Mn\ O_2 + H_2\ S\ O_4 =$$
$$3\ H_2O + P_2O_5 =$$
$$C_2H_5OH + H_2SO_4 =$$
$$2\ KI + F\ O_2 =$$

5. Write the graphic formula of Marsh Gas and (b) illustrate by graphic formulæ its relation to wood alcohol.

6. (a) What are carbohydrates? (b) Name three substances belonging to this group.

7. (a) Iodine—Give its (1) valence; (2) method of preparation; (3) test for iodine. (b) Give name and formula of one of its organic and one of its inorganic compounds.

8. How would you know that a given white powder was calomel and not ordinary bismuth?

9. Upon what chemical fact does Fehling's test for sugar depend?

10. (a) Give the most important constituents of normal gastric juice. (b) What is the action of normal gastric juice upon:

(1) Proteids
(2) Fats
(3) Carbohydrates

} in the ordinary course of digestion?

### ANATOMY.

1. Describe upper extremity of humerus, including attachments of muscles.

2. Name cavities of the heart and describe the valves.

3. Name salivary glands and locate orifice of their ducts.

4. Give foramen of exit from cranium, distribution and function of the pneumogastric nerve.

5. Name muscles of the eyeball and eyelids, and give their nerve supply.

6. Through what vessels does blood pass in going from the external saphenous vein to right index finger?

7. Name muscles on back of leg.

8. Describe the pharynx.

9. Describe gross anatomy of the liver.

10. Describe the thyroid body.

### THERAPEUTICS.

1. Explain the action of diphtheria and tetanus antitoxin as prophylactic and curative agents.

2. Write a prescription in Latin, without abbreviation, containing three ingredients which you would use in the treatment of acute pharyngitis.

3. Write a prescription in Latin, without abbreviation, containing four liquid ingredients; state conditions for which it is intended and give directions for its use.

4. Name three official preparations of ammonium and give their therapy.

5. Hyoscyamus: Its active principle, physiological action and therapy.

6. Belladonna: Its active principle, physiological action and therapy.

7. Digitalis: Its active principle, physiological action and therapy.

8. Give an example of a prescription showing a chemical incompatibility and describe the incompatibility.

9. Give the physiological action of nitroglycerine and indications for its use.

10. Name the chlorides of hydrargyrum, therapy, symptoms and treatment of poisons.

### MATERIA MEDICA.

1. Bismuth, beta-naphthol, camphor and aspirin. The official preparations and dose of each.

2. Give source of sugar of milk, urotropin, phenol, pepsin and glycerine.

3. Name the alkaloids of nux vomica.

4. Belladonna. The official preparations and doses.

5. Cocain, codein, colchicum, colocynth. The official preparations and doses.

6. Define extracts: Give five official extracts, with average dose of each.

7. Name three drugs which may produce a rash and describe such rash.

8. Write a prescription for 36 pills, for an adult, containing iron, quinine, strychnine and arsenic.

9. Name three external and three internal antiseptics and give strength in which they are generally used.

10. What are antitoxins? Name three. Give average dose and how administered.

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PHYSIOLOGY.

1. Give reaction of the following and state cause of reaction: Gastric juice, blood, urine and pancreatic juice.
2. Describe briefly the physical and morphologic changes of the leukocytes.
3. What are carbohydrates and what part do they play in the general metabolism?
4. Describe briefly the physiology of the clotting of blood.
5. Define anabolism, osmosis, dialysis and rigor mortis.
6. State some of the conditions which produce variations from the normal temperature of the body.
7. State briefly what is meant by the vasomotor nervous system.
8. Describe the fetal circulation. What changes in the circulation take place at birth? What is the physical condition of the child if such changes do not take place properly?
9. Describe the physiology of menstruation.
10. What is meant by secretions? What is the difference between external and internal secretions? Give examples of each.

PATHOLOGY.

1. Describe trichina spiralis, giving life cycle, and morbid anatomy of trichiniasis.
2. Mention two or more conditions that prevent the passage of urine from the male bladder, and describe the process which causes one of these conditions?
3. Mention six varieties of calculi and describe the formation and composition of one variety?
4. What are the signs of death? Sketch the method of doing a complete autopsy.
5. Give the pathological changes occurring in acute bronchitis
6. Mention the lesions of typhoid fever? What is a typhoid carrier and how recognized? How is anti-typhoid vaccine prepared?
7. Describe the healing of an uninfected wound.
8. Give the characteristics of a malignant growth. Mention at least four varieties which affect the breast and describe one.
9. Discuss anaphylaxis.
10. Describe the morbid process occurring in a tuberculous hip which is untreated, resulting from bony anchylosis.

PRACTICE.

1. Define: (a) Ulcerative stomatitis. What remedy is specific for this disease? (b) Argyle-Robinson pupil. In what disease does it occur? (c) Arthritis deformans. (d) Anuria, hematuria, polyuria. (e) Phlebitis. Mention a disease in which it occurs as a late complication.
2. Define: (a) Nephrolithiasis and cholelithiasis. (b) Landry's paralysis. (c) Name the various valvular diseases of the heart. (d) Enteroptosis. (e) Dysphagia. Name some diseases in which it occurs.
3. Diagnosis—Define: (a) Tonic and clonic spasms. (b) Hemoptysis and hematemesis. (c) Sibilant and sonorous rales. (d) What is Tic Douloureux and how would you treat it?
4. What are the physical signs of pulmonary solidification and pleuritic effusion?
5. Differentiate: Follicular tonsillitis and diphtheria.
6. Name the day of eruption in smallpox, chickenpox, measles and scarlet-fever.
7. Give diagnosis of intestinal obstruction and name three types.
8. Treatment: Give treatment of nephritis and name both types.
9. Being called to a case of pulmonary tuberculosis in its early stages, what symptoms would you find, and what measures would you employ?
10. Pellagra. What are its symptoms and how would you treat them?

SURGERY.

1. Give symptoms and treatment of chronic purulent otitis media.
2. Name conditions which may cause inability to pass urine, with symptoms of each.
3. Give symptoms, diagnosis and treatment of Pott's disease in the dorsal region.
4. Symptomatology and treatment of acute glaucoma.
5. Give symptoms and treatment of a fracture of a rib. What complications may arise.
6. Give symptoms, diagnosis and treatment of cholelithiasis.
7. Give symptoms and signs of thoracic aneurysm.
8. Define surgical shock: give symptoms, signs and treatment.
9. A patient having received a severe blow over left temporal region, is unconscious for a time, paralysis coming on late. Discuss the possibilities.
10. Give symptoms, diagnosis and treatment of carcinoma of the rectum.

OBSTETRICS.

1. Describe the changes that take place in the organs of the mother during normal pregnancy.
2. Give the classification of contracted pelvis.
3. Describe the sutures, fontanelles and protuberances of the presenting fetal head.
4. What is kyphosis and its influence on labor?
5. Give the diagnosis of tubal pregnancy before rupture.
6. Mention the different methods of dilitation of the cervical canal for delivery of the fetus.
7. Give the indications for version.
8. What are the dangers in forceps delivery?
9. Describe the physiological lochia.
10. Describe briefly the operation—trachelorrhaphy.

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# MEDICAL JOURNAL

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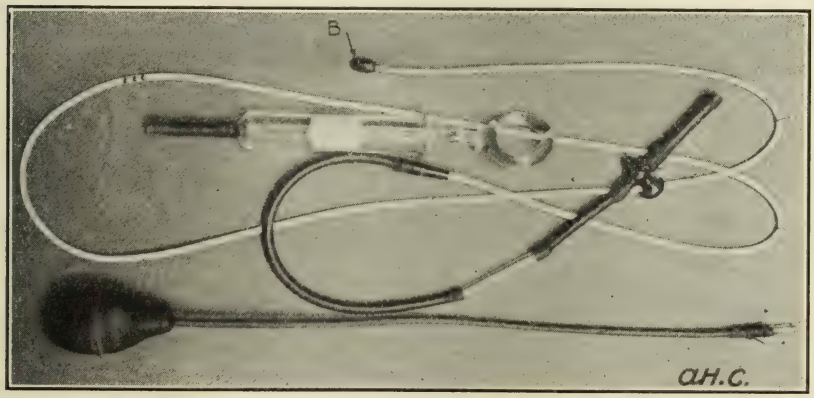
## THE DUODENAL TUBE—A BRIEF DISCUSSION REGARDING ITS USE AND VALUE, WITH REPORTS OF CASES.

*By Albert Hynson Carroll, M.D.,*
Associate in Diseases of the Stomach and Intestines, University of Maryland.



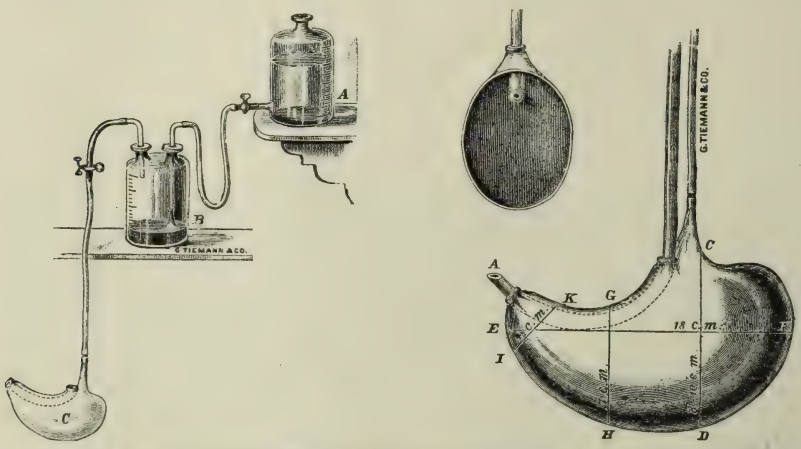

EINHORN'S DUODENAL TUBE, WITH THE GLASS SYRINGE.

To be able to penetrate into the digestive tract as far as the duodenum without pain or real discomfort to the patient, and to withdraw its content for analytical study, sidetracking the stomach and the esophagus, resting these parts when this is indicated, and allowing of the introduction directly into the duodenum of food or of therapeutic agents, is indeed an achievement which marks distinct progress in the treatment and in the diagnosis of disease.

So readily can the method be comprehended and put into practice with the duodenal tube that there is but little excuse for the practitioner who does not arm himself by becoming familiar at least with its principal uses and the technique.

It is surprising that more space has not been devoted to the new method in the medical journals. However, the literature to date, altho not great in volume, is rational, and is readily comprehended. There has been a delightful absence of false and ungrounded claims made for it. Max Einhorn, who gave us the tube, is perhaps the most modest of any of those who are using it in his claims for its merits.

With a broader knowledge of its value, the tube will, without doubt, become a part of the kit of many practitioners, who at present condemn it outright, or simply pass it over with a wave of the hand. To these it means nothing at present, and will not, unless either the prejudice which is inborn in them to any new procedure is overcome, or a broader acquaintance with the mechanics of digestion, with physiological processes, and with the repair of lesions of the upper part of the digestive tract is acquired.



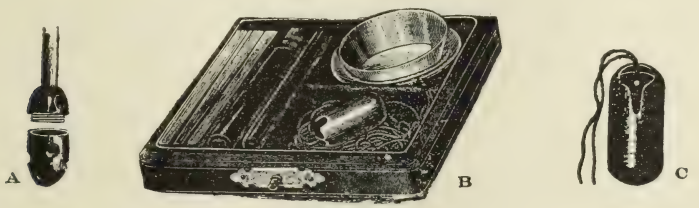

Original apparatus devised by Hemmeter and used in securing duodenal contents. Pressure bottles for distending intragastric rubber bag, and semi-diagramatic cut of the bag showing the directing groove for the slender intubating tube. An advantage of this early method is that when necessary intubation can be accomplished in a few minutes.*

For a long time studies had been carried on with gastric secretions, and gastric juice was a familiar object in the laboratory. Appreciating fully that digestion only began in the stomach, there was naturally a keen desire to investigate the enzymic activities of the contents of the upper part of the intestine, for it is here that the food residue from the stomach comes directly into contact with the copious secretions poured out by the liver and the pancreas. To do so it was necessary to secure the duodenal content under as nearly physiological conditions as was possible, and intubation was the only solution of the problem.

With this object in view, Hemmeter[1] as early as 1905 devised and used an elastic rubber bag with a directing groove, which he introduced into the stomach. When the bag was in-

*Diseases of the Stomach.—Hemmeter.

flated its walls approximated the walls of the stomach, and he was able to pass a slender rubber tube through the directing groove and on into the duodenum, and to aspirate its contents.*




A. Olive-shaped perforated metal end piece of the duodenal tube. It can be unscrewed for cleaning.

B. Bucket with a lid so arrranged that it will close when traction is made on the string, with reagents and a tray. This outfit is interesting as representing a stage in the development of this effort to secure gastric and duodenal contents for study.

C. An enlargement of the "bucket" showing the ingenious self-closing lid. At best only a small amount of material can be secured, and this may be contaminated.

The next attempt to invade the duodenum was made by Einhorn in 1908, with that ingenious little contrivance, the duodenal bucket.[2] The bucket was supplied with an automatically-closing lid, which did not, however, prevent frequent contamination of its contents when it was being used. It is of use in diagnosis only, and with it but a very small amount of the secretions can be obtained. The ease with which the bucket could be gotten into the duodenum, being carried there by peristaltic movements of the stomach, no doubt suggested that a slender rubber tube be substituted for the thread, and that the bucket be supplanted with a perforated metal extremity, and about a year later Einhorn gave us the method of intubating the duodenum with his duodenal tube.[3]

This consisted of a slender rubber tube 0.2 c.m. in diameter and 90 c.m. in length, attached to an olive-shaped and perforated metal capsule. The tube as now used is marked at 40 cm., to indicate when the bulb has reached the cardiac orifice, at 56 cm., the pylorus, and at 70 and 80 cm. When the 70 cm. mark has reached the incisor teeth the bulb should be *in situ*.

The proximal end is provided with a two-way stop-cock, and a glass syringe is used for aspirating the contents.

Gross[4] devised a similar apparatus almost simultaneously. It differs only in that he has marked his tube at every 10 cm. and has placed a receiving bulb in the tube between the mouth and the syringe. It is 125 cm. in length. The tubes are essentially the same.[5]

When Kussmaul, in 1873, introduced gastric lavage into the-

*It is a matter of interest to recall that it was Hemmeter who first suggested photographing the human stomach with the bismuth X-ray method, the development of which has enlightened us as regards the true shape of this organ. See Hemmeter, "Photography of the human stomach by the Rentgen Rays." Boston Med. and Surgical Jour., 1896.

rapeutics by extending the use of the stomach tube, a step forward was made. Shortly after this Leub found further use for it, and demonstrated that the tube was of value in diagnosis, as well as in the treatment of disease. So it was when Einhorn first gave us his method of alimentation. Immediately many new possibilities became evident, and new uses were discovered for it not only in treatment, but in the field of diagnosis as well. Space will prevent my going at all thoroughly into the subject, but I shall indicate some of the conditions in which the tube may be used with advantage, and following a brief description of the technique of the introduction I will venture to place on record several new cases in which the value of the tube in diagnosis and in treatment was beyond question, hoping that this will stimulate some of my readers to a more general interest and use of this recent addition to our armamentarium.

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With the tube duodenal secretions can be secured for a study of their enzymic activities, and for the presence of blood.[6] If no blood has been found in a previous examination of gastric contents, and it is found in the duodenum, we may look upon the tube as an instrument of precision. In several cases where the location of an erosion was a matter of doubt, I have been able to positively state before operation that we were dealing with a duodenal ulcer. Three of these cases were operated upon by Dr. Frank Martin, and a pylorectomy done. In two cases the laboratory report was beginning carcinomatous changes. When it is remembered that the duodenal erosion has not been generally regarded as a seat for future cancerous growth, it appears to me that to be able to at times definitely state the location is a matter of some interest.

The study of the enzymic activities of the duodenal content does not appear to be one of academic interest only. Much remains to be done in this line of investigation before we will be able to draw many definite conclusions from the studies. However, we are able to tell if the duodenal content is potent as regards the digestion of fat, of starch and of proteid, both quantitatively and qualitatively.

The studies of Hertz, of Cannon and others, with the aid of the X-ray, have given us a fair idea of the normal rate of progress of the food residue through the several anatomical divisions of the digestive tract.[7] Hence, in any study of the stool it appears to me that if we know just how long the food residue takes to traverse the stomach, to pass through the small intestine, and to reach the pelvi-rectal flexure, and supplement this with the information we can secure from a study of the activities of the secretions of the stomach and of the duodenum, we will be in a position to better interpret the stool picture. If it is true that cellulose disappears under prolonged bacterial action in the bowel, we can

conceive readily how we may go astray on stool examinations unles we co-ordinate the information above referred to.

Zeisler sums up well when he stated that we are living in a period today when the pathological laboratory has become indispensable to us in our work, but we should not use it in the pursuit of fads; we should not forget that, alter all, the laboratory should be our aid, our assistant, not to say our servant, and not our master. The methods of investigation have been quite well worked out in regards to the action of the various enzymes. It remains, however, for us to learn to piece together the information in order to form the picture we wish to read. Although such laboratory studies are of intense interest, it is the less difficult and more practical uses of the tube which we are interested in calling attention to in this short paper.

Without doubt the very greatest use the tube can be put to is in duodenal feeding, where, for any reason, it is necessary to nourish the patient, and yet spare the tract from the irritation of food, either in passing through the esophagus, the stomach or in the duodenum. With these parts put at rest an ulcerated or eroded area is given the best opportunity to heal, since the tube sidetracks the diseased area. The use of it in the treatment of ulcer alone would warrant its existence.

Lenhardt, Osler, Kemp, and in fact all clinicians, appreciate the fact that the ideal treatment as regards furthering the healing of an ulcer is to put the part at rest. And yet, no doubt, we are dealing with more than ulcer alone when we treat these cases, and it now appears that we have good grounds for thinking that an ulcer is only a manifestation. That after all we are confronted with *"gastric or duodenal ulcer disease,"* and as there is no specific treatment, the patient must be nourished and put in as good condition as possible to combat or aid in the return to a normal state.

But food in the stomach in sufficient quantities to supply the normal demands of the body not only distends the gastric bag, but by its very presence *stimulates peristalsis and gastric secretions.* Furthermore, if we distend the walls of the bag, we may also stretch the base of a healing erosion. The duodenal tube allows of the delivering of food and therapeutic remedies distal to the pathological area. We sidetrack it and rest it.

At times we wish to lavage the duodenum in so-called catarrhal jaundice. Recently Jutte has called attention to another possibility of the duodenal tube, in what he has termed transduodenal lavage. "This is to the small intestine what enema is to the colon." From 1000 to 1200 c.c. of normal saline solution is employed by the drop method in intestinal toxemias with their many-sided sequelae and the various types of catarrhal enteritis. Einhorn has reported a series of cases of acute conditions of the liver, where he found that with duodenal feeding the hepatic congestion disappeared rapidly. Ipecac can be placed directly into the duodenum in cases of amebic dysentery with excellent results.

The progress of the patient when under treatment for disorders which are evidenced by disturbances in the gastric secretions, can be studied from day to day, with much less inconvenience to the patient and without the confusion which often arises from regurgitated duodenal secretions when the stomach tube is used. I refer to those patients who suffer from irritable throats or who, from other causes gag and retch when the stomach tube is used, and in this way return duodenal alkaline secretions into the stomach.

It is but seldom that a patient is met with who finds the slender tube either difficult to swallow or irritating. It is truly remarkable with what readiness they learn to retain the tube indefinitely, and the lack of discomfort experienced.

In certain cases where there is a persistent reflex vomiting, due to inflammation which has extended to the duodenum, as in gall bladder disease, the use of the tube may be the only means by which the vomiting can be checked. The first case reported well illustrates this point.

In pylorospasm and in spastic conditions of the esophagus or of the cardiac orifice of the stomach, feeding can be carried out once the bulb has passed the spastic area. With one tube in the duodenum a second tube may be placed in the stomach where there is a gastro-succorrhea and the hypersecretions siphoned from the gastric bag. I have only tried this in a few cases, and altho the procedure appears to me to be worth the trial, I have not as yet used it in a sufficient number of cases to warrant any statement as to the practical advantage of the method.

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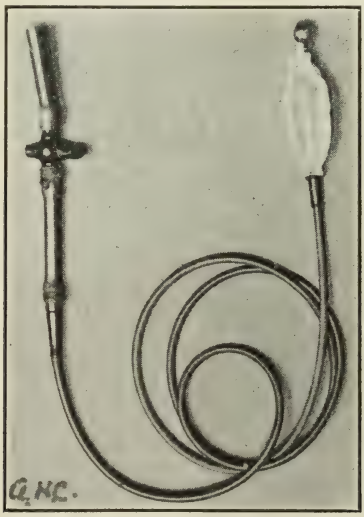
*Technique of introduction:*[8] The object to deliver into the duodenum the perforated globular extremity of the tube. The technique is simplicity itself. There is seldom any choking on the part of the patient, and only a moderate degree of patience is required by the investigator.

The bulb is placed well back on the patient's tongue, and he may be given a few mouthfuls of water to aid its passage into the stomach. No other lubricant is required. The patient should breathe through the mouth until the tube has entered the stomach. He is now told to lie on his right side. It is well to gently direct or guide the tube into the mouth, but no effort should be made to force it, as this will surely result in a doubling up of the tube. In guiding the tube you will overcome any traction which might occur if it is allowed to hang down or drag on the patient's clothing.

When the first mark has reached the incisor teeth we know that the bulb should be entering the stomach. It is my rule to aspirate some gastric content at this stage for study and for comparison with the contents of the duodenum, to be secured later.

After having withdrawn the gastric specimen *fill the tube*

*with water and turn off the cock*, allowing the tube to hang down over the edge of the bed, after securing the tube near the third mark to the cheek with adhesive. When the third mark has reached the teeth, the cock may be opened and duodenal content, in nearly every case, will siphon from the tube. Frequently while watching patients after the tube has been swallowed and the cock left open, I have been able to *tell exactly when the tube has reached the duodenum* by observing the change of color in the fluid dropping from it, from a colorless to an orange-green. The texture of the fluid also at once proclaims it to be duodenal rather than gastric content.

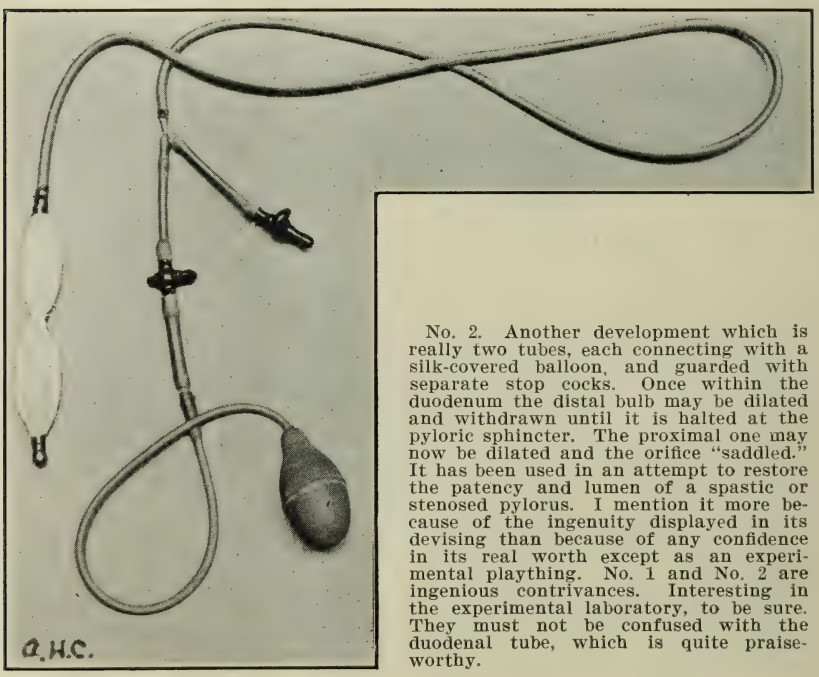


No. 1. This is a duodenal tube with a balloon attached to its end. When in the duodenum it can be dilated. Its real use has as yet to be proven except perhaps as a means of locating the pylorus and experimentally determining its patency. With it a spasm may at times be differentiated from a partial obstruction. It has been used in an attempt to relieve the former condition. Such a contrivance may be utilized in duodenal transillumination. Experimentally interesting, but in my opinion of little value.

This knowledge of the time required for the stomach to pass the bulb into the duodenum must not be overlooked, as it may serve as an indicator to the peristaltic activity of the stomach.

Occasionally the tube will become doubled up in the stomach, and the bulb not enter the duodenum. A drink of milk may be given as a test, and if this can be aspirated immediately, the tube must be partly withdrawn and another attempt made. In a certain percentage of cases real or imagined difficulties to the passage of the tube into the stomach are met with. When the difficulty is not in the nature of a true obstruction, the tube may be threaded on a flexible director. On one occasion I was compelled to borrow a piece of wire from the patient's electric doorbell, and when the insulation was removed it served its purpose very well.

As previously mentioned, the filling of the tube with water after it reaches the stomach, and allowing it to hang at a lower level than the patient, will often obviate the necessity of using the aspirating syringe, and the siphoning of the content will begin and continue after the stop-cock is opened. However, when this does not come about the process may be initiated with the syringe, but only a gentle vacuum must be created. Otherwise the tube will collapse at the most compressible portion, and this will result in suction distal to the collapsed portion being done away with.




No. 2. Another development which is really two tubes, each connecting with a silk-covered balloon, and guarded with separate stop cocks. Once within the duodenum the distal bulb may be dilated and withdrawn until it is halted at the pyloric sphincter. The proximal one may now be dilated and the orifice "saddled." It has been used in an attempt to restore the patency and lumen of a spastic or stenosed pylorus. I mention it more because of the ingenuity displayed in its devising than because of any confidence in its real worth except as an experimental plaything. No. 1 and No. 2 are ingenious contrivances. Interesting in the experimental laboratory, to be sure. They must not be confused with the duodenal tube, which is quite praiseworthy.

It is interesting to note the irregular dropping of the content from the end of the tube. When all is going well the dropping will become at rythmic intervals almost a continuous stream. This alteration in the continuity of the flow is largely dependent on the alteration in the intra-abdominal pressure accompanying the respiratory act. We can often secure an additional amount of duodenal content by having the patient take a deep breath when it has ceased to siphon and when the aspirating syringe fails to withdraw a further amount. I think that there is an increase of pressure on the very compressible tube at the sphincters, and when a partial vacuum is created it collapses at such a point. Frequently a tenacious mucous material will siphon through the tube, while any attempt to aspirate it will result in complete failure through the *collapse of the tube.*

BRIEF REPORT OF CASES TREATED WITH THE DUODENAL TUBE.

Case No. 1—Hospital No. 1234; Mrs. J. E.; age, 43; entered hospital April 23, 1913; left hospital June 12, 1913.

As regards past history, there is nothing which sheds any light on the present trouble. The patient has been a very healthy woman all her life. She was perfectly well up to several weeks before *being carried into the hospital,* and for two months prior to the onset of the present trouble she had nursed three children ill with typhoid fever. Two weeks before entrance she developed acute pains in the epigastric region, and thought she had "acute indigestion." The pain became almost constant, and there was great tenderness in the upper right quadrant also, but there was only an occasional attack of vomiting for the first week.

She was under the firm conviction that she had contracted typhoid from the children. Six days before entrance she began to vomit after *each attempt to take food or water.* She says the vomited matter was nearly always greenish, and that it made her "burn like fire" in the esophagus and stomach. Every time she swallowed there was an intense burning sensation in the throat and esophagus. She was "famished for want of a drink of water." Her mind was perfectly clear at all times. An ice bag over the upper abdomen gave but little relief. She had been a stout woman, and there was still much adipose tissue. There was pressing need for supplying fluid to the tissues.

The patient's family physician had diagnosed gallstones early in the attack. During the blood examinations a Widal was made. This was positive. Two later tests were also positive.

I did not see the patient until five days after she had been brought into the hospital, when I was called in consultation by Dr. Randolph Winslow. Proctoclycis had already been instituted, and had been persevered with, although the patient was retaining only a small amount. *The vomiting occurred after every effort to ingest food or fluid.* The vomiting matter was bile-stained, and consisted mostly of ropy mucus. It was negative to visible or to occult blood. More fluid was being ejected than we were able to introduce.

Bismuth was given several times before a sufficient quantity was retained long enough to secure an X-ray examination. Finally two plates were secured. The immediate plate showed the stomach to be in active peristalsis. Some bismuth had already entered the duodenum. The one-hour plate discovered the stomach to be completely empty, and the bismuth was well on its way to the cecum. There was no evidence of adhesions around the pyloric end of the stomach, nor was the pylorus drawn over to the right.

This was evidently a case of duodenal spasticity, probably secondary to gall bladder disease, with a regurgitation of contents into the stomach.

Here was an opportunity to furnish fluid and food to a famishing person, provided the spastic area could be sidetracked with

the duodenal tube. It was a matter of doubt if the tube could be introduced and the bulb passed beyond this spastic area.

The possible typhoidal condition had to be borne in mind, and yet there was no doubt that an exploratory operation was indicated. The condition of the patient's heart and her general state forbade even the giving of an anesthetic at this time. Pulse, 120; respiration, 24; slight discoloration of the sclera; hemaglobin, 65; whites, 6000; reds, 4,000,000.

Her mind remained perfectly clear during the entire illness. Her suffering was intense at times. She was a very ill woman.

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After persistent efforts the duodenal tube was retained, and passed on into the duodenum. Almost pure bile in quantity was secured. Feeding was at once begun. For three days the tube could be retained for only a few hours at a time. After the third day it would stay in place over night. The patient was given egg albumin, peptonized milk, beef broth and water at two-hour intervals up to 2800 calores a day. After the fifth day she did not vomit, and her improvement and gain in strength was truly interesting. The fourteenth day her hemaglobin was 80; reds, 4,500,000; whites, 9000; pulse, 90; respiration, 20. She was taken to the operating room, and was operated on by Dr. Randolph Winslow. Several stones were removed from the gall bladder, and about 250 c.c. of pus was evacuated. Four weeks later the patient left the hospital a well woman. * * * * *

Although the X-ray examination was a matter of rather good fortune, and was not an ideal one, it served to demonstrate that there was a duodenal irritation; that the stomach was hypertonic; that active peristalsis was present; that there was a rapid emptying of that organ when its content was not vomited. Here were three of the four conditions forming the symptom-complex which Hertz[9], Rowden[10] and Barclay[11] and others hold to as diagnostic of duodenal irritation. The fourth is lacking in this case. "Food was not seen passing through the duodenum, with or without a persistent shadow in some part of the duodenum." Had a fluoroscopic examination been possible, this point also would, no doubt, have been added.

The point is this: Had it not been possible to build up this patient with duodenal feeding, she could have survived but a few days. An imperative operation could not have been performed in her condition on entrance, and there is no reason to believe that the vomiting would have ceased or could have been otherwise controlled. All usual efforts had been attempted for five days before I was called in by Dr. Winslow, with no success whatever. The duodenal tube *solved the problem.* Simon has recently reported two very similar cases.[12]

Case No. 2.—This case illustrates the use of the tube in a selected case where the object in view was *not to cure the patient,*

*or to aid in any way,* except from the symptoms of pressure due to acute dilation and an obstructive condition.

Six days after an apparently clean operation for appendicitis symptoms of acute dilation and obstruction began and rapidly became marked. The pressure symptoms from the distended gastric bag became rapidly worse. For several days the stomach was emptied of its contents every two hours with the stomach tube. Some relief from the dysponea and intra-gastric pressure lasting but a short time, followed. The usual efforts were made in this case to bring about a change without avail. The patient was away from home, and it was not thought wise to open the abdomen again without consulting with the family, and for other good reasons. She was in extremis. The passing of the stomach tube was in itself a dangerous tax on the small store of vitality. *Circumstances prevented* even this method *for a period,* and at this time it appeared to me that if the duodenal tube could be gotten into the stomach, *constant siphonage* would follow, and the contents would be removed *as soon as they had appeared* in the bag. This was done, and the tube remained in place from the first, *i. e.,* from 12 M. until 9.30 P. M., when the abdomen was opened.

The content was slightly yellowish the first hour or so, and flowed in an almost constant stream. About two liters were collected the first four hours. A quantity of gas was also liberated. Later the siphoning content became rapidly fecal in odor, much darker in color, and without doubt contained disintegrated blood. The patient's respiration was less labored than at any time, except immediately after evacuation by the stomach tube, before its use was interrupted. The pulse, though alarming, became fairly constant in tension and rate. The patient undoubtedly went to the operating-room in a far better shape than if she had increasing distention and pressure up to *the maximum* of capacity and endurance to fight with, each two hours. In other words, we furnished more room, and maintained a state of lessened intra-gastric pressure, which was then equal to the pressure which had to be contended with immediately following the intermittent stomach tube evacuation.

Case No. 3.—Patient, H. L. H.; white; male; age, 27; occupation, packer. This case may be considered somewhat atypical, in as far as there were no hunger pains, and the discomfort was fairly constant. Food did not relieve the pains, which came on about two or three hours after eating. At no time did he notice that he was awakened at any time at night with pain. He had had a gradually increasing "dyspepsia," as he called it, for three years. Occasionally he would vomit about one-half hour after eating. This did not relieve the pain, which was located in the epigastric region. This was burning in character, but not severe at any time. The symptoms had not been more marked during cold weather. He had never seen blood in his vomit, but often

had noticed streaks of blood in his stools. He did not know if the stools had ever been "tarry" in color. He had been constipated for three years. He had been a very healthy, well man up to the present trouble.

The physical examination was negative as regarded the heart, lungs and urine. The blood picture was not illuminative. There was a moderate degree of visceroptosis, with a subxyphoid angle of 70°, and both tenth ribs floating. (Stiller's sign.) There was a sensitive area on pressure in the region of the gall bladder. An X-ray examination showed active peristalsis, with no bismuth in the stomach after two hours. There was no evidence of adhesions in the pyloric region. Examination of the rectum discovered a congested condition and hemorrhoids. The sigmoid was also somewhat congested. No ulceration. *Any blood found in the feces could easily have been ascribed to this source;* or to higher up in the colon.

Analysis of three test meals showed free HCl, 25 to 30°, but no blood. No retention (macroscopic) of the early meals. A Hausmann "fasting stomach test" with rice was made. Twenty c. c. was obtained, and this was *microscopically positive* for starch. Slightly bile stained. No blood.

The "string" test was negative for blood. Since the stools had appeared to be poorly digested, and to contain an excess of fat, I decided to draw the duodenal contents to test its enzymic values with the Einhorn agar-starch, agar-olive oil and agar-hemaglobin tubes.[10] The stomach had been washed clean, and a glass of boiled milk given during the introduction of the duodenal tube. In one-half hour duodenal siphonage began, and there was a flow of pinkish blood-stained fluid. The tube was withdrawn into the stomach and gastric content secured. This was blood free.

Patient operated on by Dr. Frank Martin. After exposing the pylorus and duodenum absolutely no evidence of the ulcer was found, except at one spot there was a suspicion of a slightly anemic spot just distal to the ring. This area or no other was indurated or thickened. The pylorus was patent. Pylorectomy and gastro-enterostomy was decided upon, however, as I was convinced that an ulcer was present. In making the circular incision an ulcerated area 2 to 3 sq. cm. was exposed.

Patient left hospital July 30, 1913, apparently a well man. Reported August 31. He had gained 12 pounds.

Operation was not undertaken in this case until medical means had been found of no avail. Pylorectomy, when done by a skilled surgeon, is without doubt the operation of choice. Rodman, as far back as 1906, advocated excision or pylorectomy in pyloric ulcer cases.[14] Tuffier holds that every solitary and easily accessible gastric ulcer should be extirpated.[15] Martin has operated on two cases recently for ulcer in the duodenum close to the pylorus, in which I used the duodenal tube as an aid to diagnosis. The microscopic findings were beginning malignancy.[16] In neither

case was there macroscopical or clinical evidence of the change taking place at the site of the ulcer. A strong argument for pylorectomy in this class of cases.

Case No. 4.—Mr. L. The patient had had indigestion for several years, with attacks of vomiting and definite symptoms of duodenal ulcer. He had been jaundiced frequently, but had at no time experienced a typical attack of gallstone colic. There was a marked visceroptosis. An X-ray series made by Dr. Baetjer showed marked hypermotility of intestines and active gastric peristalsis. Also apparently some adhesions in the pyloric region.

Test meals: Free HCl, 45 to 80°. Positive evidence of retention. No blood at any time except once, when bile was present. This was always the case *when the stomach tube was used.* The acidity, however, was only high as regards the free HCl when gastric contents were *aspirated with the duodenal tube.* Retching would cause a return into the stomach of neutralizing duodenal alkaline secretions. One bile-laden meal contained no free HCl and blood.

Abdomen opened by Dr. J. M. T. Finney. No sign of ulcer of stomach or duodenum. Adhesions found around gall bladder and broken down. Two small gallstones removed. Uneventful recovery. Six months later many of the old symptoms returned. April, 1913.

My diagnosis was *duodenal ulcer,* and was based on the fact that on two occasions red blood in *large amount was aspirated from the duodenum.* At operation there was found a thickened gall bladder wall and some adhesions, but not an acute inflammatory condition. I still hold from later study of this case that the blood was from a duodenal ulcer which was *not discoverable* at operation, and that the ulcer disease was distinct from the gall bladder condition; that he had two definite pathological conditions. The points I wish to bring out are these: The analysis of the gastric content was subject to error when the stomach tube was used, due to regurgitation of duodenal content and the neutralization of its free HCl. The duodenal tube brought up gastric content alone when it was used to secure gastric content, *blood and bile free.* When used to aspirate the duodenal content red blood was secured, the origin of which is an open question.

It has not been my object to enumerate all of the uses to which this little instrument can be put. I have endeavored, however, to demonstrate that it is a valuable aid in certain cases, not only in treatment, but in arriving at a diagnosis also.

343 Dolphin Street, Baltimore, Md.

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[I wish to thank Drs. Martin and Winslow for the privilege of studying these cases previous to operation and for encouragement in this somewhat new field of work, and Dr. Maldeis and Dr. Lichtenberg for generous laboratory aid in blood, stool and gastric analyses, which lack of space prevents incorporating in this type of report in full.]

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STUDIES CONCERNING GLYCOSURIA AND DIABETES. By Frederick M. Allen, A.B., M.D. Boston: W. M. Leonard. 1913.

The above mentioned book represents three years' work in research in the Laboratory of Preventive Medicine and Hygiene of the Harvard Medical School.

Up to the present Allen's contribution on diabetes are the most important in the English language and will stand as a model for future investigators for years to come. He has covered the field systematically as well as scientifically, and seems not to have left a stone unturned or a possible avenue of investigation untouched in making the monograph as complete as human labors can. One need only to superficially glance at the book to realize instantly the amount of energy he expended in getting his material together. The experimental part of the work alone is a sufficient life labor for most men, let alone the compiling and putting into intelligent and readable form the results of these labors. Undoubtedly Allen's researches will change our ideas to a large extent concerning carbohydrate metabolism, and will go a long way to clarifying the atmosphere of the mist of confusion surrounding this very alluring disease. Nobody interested in metabolic diseases can afford to be without this book, as it is the very last word upon the subject.

# ON THE REPORTING OF COMMUNICABLE DISEASES.

*By C. W. G. Rohrer, M.D.,*
Maryland State Department of Health.

(*Continued from September Number.*)

From the viewpoint of numbers, Baltimore county holds second place in the foregoing table; but, for all that, I can only classify the returns from this county as "good." Taking the number of cases reported (961) and comparing them, population for population, would bring Baltimore county several places lower down in the list.

The city of Baltimore, with its area of 31.64 square miles and a population numbering 558,485 souls, being a separate public health jurisdiction, is not discussed in these pages. Its Health Department, under the guidance of Dr. Nathan R. Gorter and Dr. C. Hampson Jones, is not only one of the oldest, but also one of the greatest in this country.

The populations given above are in accordance with the Federal census of 1910. Fourteen of the counties of Maryland—Allegany, Baltimore, Calvert, Caroline, Carroll, Dorchester, Frederick, Garrett, Montgomery, Prince George's, Somerset, Washington, Wicomico and Worcester—show an increase, while nine—Anne Arundel, Cecil, Charles, Harford, Howard, Kent, Queen Anne's, St. Mary's and Talbot—show a decrease over the figures for 1900.

To summarize: In the above classification but two counties—Allegany and Washington—are classified as "very good;" 11—Baltimore, Frederick, Carroll, Anne Arundel, Dorchester, Prince George's, Montgomery, Somerset, Howard, Worcester and Cecil—are classified as "good;" six—Talbot, Caroline, Kent, Harford, Calvert and Queen Anne's—are classified as "bad," while four counties—Charles, Wicomico, Garrett and St. Mary's—are classified as "very bad."

Before quitting this important section of my paper I desire to discuss briefly another feature in the work of the Maryland State Board of Health wherein it is decidedly in advance of that of most other States. I allude to the reporting of occupational or industrial diseases, which law, enacted at the legislative session of 1912, reads as follows:

THE LAW RELATING TO REPORTS OF INDUSTRIAL DISEASES.

*Chapter No. 165, Acts of 1912.*

SECTION 1. Be it enacted by the General Assembly of Maryland, That a new Section be added to Article 43 of the Code of Public General Laws of Maryland of 1904, title "Health," sub-title "State Board of Health," to follow after Section 5 of said Article, to be known as Section 5A, be and the same is hereby enacted to read as follows:

SECTION 5A. Every physician attending an or called in to visit a patient whom he believes to be suffering from poisoning from lead, phosphorus,

arsenic or mercury or their compounds, or from anthrax, or from compressed air illness, or any other ailment or disease contracted as a result of the nature of the patient's employment, shall send to the "State Board of Health" a written notice stating the name and full postal address and place of employment of the patient, and the nature of the occupation and the disease from which, in the opinion of the physician, the patient is suffering, with such other specific information as may be required by the "State Board of Health." If any Physician, when required by this Section to send a notice, fails forthwith to send the same, he shall be liable to a fine not exceeding five dollars. It shall be the duty of the State Board of Health to enforce the provisions of this Act, and it may call upon the local boards of health and health officers for assistance, and it shall be the duty of all boards and officers so called upon for such assistance to render the same. It shall furthermore be the duty of said State Board of Health to transmit such data to the Chief of the Maryland Bureau of Statistics and Information, who shall record said data and include the same and a summary thereof in his annual report.

SECTION 2. And be it enacted that this Act shall take effect from the date of its passage.

As occupational diseases are scarcely communicable in the ordinary meaning of the term, excepting in their relation to tuberculosis, I shall not elaborate further upon them at the present time, but shall subsequently discourse upon them more fully in a special paper.

## VII. LESSONS TO BE LEARNT.

There are lessons of duty, of patience and of good-will to be learnt in the reporting of communicable diseases. Happily, the stern behests of duty are in themselves sufficient in most instances to compel physicians to report their cases. But there are still a few members of our profession who are derelict in the performance of this important public duty, and who thereby cause much disorder and confusion in the daily routine of public health work. Fortunately, these are in the minority, and I am optimistic as to the ultimate outcome, feeling sure that the delinquents will soon see the error of their way, turn from it and join the ranks of the faithful before it is too late.

Surely no conscientious physician could enjoy serenity and peace of mind if he realized that he had defied the public health laws or wilfully neglected to comply with their requirements. Such a step would be a violation of his sense of honor and justice, and out of harmony with the Hippocratic oath,[43] whose mandates he is expected to obey. Comparatively few medical schools, however, take the time and the trouble to do obeisance to this ancient code of professional ethics, of which the following is a true copy:

### "THE OATH.

"I swear by Apollo the physician, and Aesculapius, and Health, and Allheal, and all the gods and goddesses, that, according to my ability and judgment, I will keep this Oath and this stipulation—to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lec-

ture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practise my Art. I will not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, of freemen and slaves. Whatever, in connexion with my professional practice, or not in connexion with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times! But should I trespass and violate this Oath, may the reverse be my lot!"

By referring to the tables showing the status of the counties of Maryland in the reporting of communicable diseases, it can readily be seen that much remains to be done in this important field of public health inquiry. A few of the counties are notoriously defective in sending in these returns, notably St. Mary's and Garrett. Wicomico is not much better.

It would be impossible to make any intelligent person believe that only three cases of measles occurred in Garrett county in the year 1912, with 1013 cases just over the line in Allegany county.[44] It would also be equally absurd to imagine that so large a county as Garrett—the largest and youngest in the State—although peculiarly free from negro population, should not have had in it throughout the entire year of 1912 a single case of whooping cough, chicken-pox, mumps, influenza or German measles.

Besides 35 cases of typhoid fever in Wicomico county, I must give that large and populous county, so prolific in colored folk, credit for one case of scarlet fever (it must have been a curiosity), six cases of diphtheria and two cases of whooping cough. We are taught that "figures don't lie," but if we are to believe the story they convey to us about Wicomico county, then that county is certainly one of the healthiest spots on the face of the globe, because not a solitary case of measles, chicken-pox, mumps, influenza, German measles, smallpox, malaria, cerebro-spinal meningitis, anterior poliomyelitis, acute dysentery or occupational disease occurred down there in 1912. It's no wonder the three or four physicians practicing in Delmar, just on the Maryland-Delaware line, didn't know enough about measles to report their cases to the Wicomico county health officer during the recent outbreak at that place.

Again, take St. Mary's county, the oldest of all and famous in the early history of the State.[45] During the entire year of 1912 nothing but 13 cases of diphtheria happened in St. Mary's. Ty-

phoid fever, according to the infectious disease returns for 1912, is unknown in that county.

I also wish to call the attention of the numerous hospitals and dispensaries throughout the State to their usual laxity in reporting cases of communicable diseases, especially the dispensaries.[16] Some time ago, when collecting data on hookworm disease in Maryland, I received the following interesting and highly suggestive letter from Mr. Hindley:

PRESBYTERIAN EYE, EAR AND THROAT CHARITY HOSPITAL,
1007 East Baltimore Street.
Baltimore, Md., February 13, 1913.

C. W. G. Rohrer, M.D.:

Dear Sir—In reply to your circular-letter relative to *hookworm disease*, we beg to say that the nature of our work at this hospital has not as yet revealed any cases. If, however, such cases are observed in future, we shall willingly comply with your request for a report.

May I suggest that there is great laxity in dispensaries generally in reporting cases of communicable disease, and that some means should be adopted to make such reports obligatory upon the doctors under whose notice they come.

Yours faithfully,
A. F. N. HINDLEY,
Registrar.

Although the physician's pathway is not always strewn with sweet-smelling roses, yet it is my pleasure and my delight to record the fact that but few shrink from the performance of their legitimate duties. Most physicians are thoroughly imbued with the proper spirit of their calling, and, consequently, exert themselves to the utmost to perform the functions of their art in strict accord with their cherished ideals. A hundred years ago when William Wordsworth (1770-1850), the principal of the "Lake Poets," wrote—

"The primal duties shine aloft like stars,
And charities that soothe, and heal, and bless,
Are scattered at the feet of men like flowers,"

he probably meant, in fine, the monumental work performed willingly, cheerfully, without money and without price, by the great body of self-sacrificing physicians who, looking neither to the right nor to the left, immolate themselves completely upon the altar of professional devotion.

## VIII. SUMMARY AND CONCLUSIONS.

Surely no physician who has attentively read this imperfect paper would care to face the trying ordeal of having failed to report a case of communicable disease, with all its harrowing details, its incivilities, its embarrassment and its humiliation. The State Department of Health is doing all in its power to make it real easy for a physician to comply with the law, whose machinery, when once set in motion, it is difficult to check in its onward progress.

Every day at least two or three Baltimore county infectious disease reports are sent to the Baltimore City Health Department

by the physicians in attendance. Although this is not radically wrong, it delays and complicates matters pretty considerably. Such an oversight means that Dr. Gorter must remail the card to this office, which, in turn, is compelled to make a copy of it and mail to the district health officer in whose jurisdiction the disease originated. Once more I desire to say that all cases of contagious disease occurring beyond the corporate limits of Baltimore city are required by law to be reported to the local health officer in whose jurisdiction the case or cases originate. Kindly use a separate card for each case, giving full name, address and all other data requested. Additional infectious disease cards can be obtained from the health officer or from the State Department of Health, and all for the asking.

From B. C. 1490, when Moses proclaimed leprosy a reportable disease, down to A. D. 31, when the startling announcement was made in the synagogue at Capernaum, a city of Galilee, that "Peter's wife's mother lay sick with a fever," on down to the present age and generation, the reporting of communicable diseases has been the bounden duty of physicians, parents and householders. This problem clearly brings into play the interests of the public and the medical profession, the oldest profession extant, adorned and edified by St. Luke, and even the Son of Man Himself.

Looking backward a score or more of years, I note that the hand of time hath wrought wondrous changes. This observation applies alike to the surface of the earth, to our social condition, to our manner of living and to ourselves. Industries have risen and fallen, and others have sprung up, phoenix-like, to take their places. The countryside, once so flourishing and populous, has almost been deserted owing to the influx of the inhabitants to the towns and cities. Even the practice of medicine is not what it used to be. Formerly everyone wanted the elderly physician because of his rich experience and mature judgment; now it is the young physician, fresh from the wards of the hospital and with the aroma of the laboratory permeating his clothing, who is desired.

War, pestilence and famine, the three fell destroyers of the human race, have devastated the earth from the earliest ages down to the present time, and these will continue their work of destruction and death, in the first instance, until the swords of belligerent nations have been beaten into plowshares and their spears into pruning hooks; in the second, until physicians throughout the land promptly report the first case of epidemic disease in a community,[47] and health officials are equally expeditious in instituting all necessary measures to prevent its spread. Then we also shall have averted the third great destroying factor, famine, which almost invariably follows in the wake of the first two Captains of the Men of Death.

This paper is written primarily for the country practitioners, that immense army of noble workers who form the very bone and

sinew of our profession, and from whose ranks have come such honored names as Edward Jenner, Robert Koch, Samuel D. Gross, J. Marion Sims, Ephriam McDowell, D. Hayes Agnew and a host of others. My heart goes out unto these tireless messengers of hope and healing and good-will,[48] and all the more so when I behold the fabric of their art shaken to its very foundation by the refinements of specialism. But may the reverse ultimately be the case, and, like Abou Ben Adhem, "may his tribe increase" and inspiration come from his noble example!

For many of the thoughts and suggestions contained in the present paper I am indebted to Dr. Fulton, that "Guide, Philosopher and Friend" for more than half a score of years, whose example of industry, devotion to duty and uprightness of character has been a lesson and an inspiration to us all. I shall embrace this opportunity of publicly recording my appreciation of his kindness by addressing to him the following letter:

"Bloomfield," Lauraville, Baltimore, May 20, 1913.

Dr. John S. Fulton,
Secretary State Department of Health,
Baltimore, Md.

Dear Dr. Fulton—I am now about to conclude my rather prolix, yet withal affectionate, *billet doux* to the 800 physicians practicing medicine in the counties of Maryland. At your earliest convenience I trust you will do me the courtesy to peruse these pages, hoping their intrinsic merits may be such as to win your approbation.

By no means have I exhausted the subject. Far from it. Indeed, I have merely blazed a more definite trail through the almost trackless waste of ignorance in the reporting of communicable disease. However, if the route which I have laid down herein be devoutly followed, I believe much good will result.

Assuring you that my sole object in preparing this paper is to be of service to you in getting better reports of infectious diseases occurring in the counties of Maryland, I have the honor to be, with expressions of my high personal regard for you and of my abiding interest in the work,

Very sincerely yours,
C. W. G. ROHRER,
Acting Chief, Bureau of Communicable Diseases.

It has seemed fitting to me to round out this little schoolboy "composition" by quoting the stanzas of the late Will Carleton's exquisite poem entitled "The Country Doctor." Doubtless many of you have read it before and have misplaced it or forgotten it. It is a just and glowing tribute to the worth of that greatest of all benefactors to the human race,[49] namely, the country practitioner. The poem is this:

"THE COUNTRY DOCTOR.[50]

"There's a gathering in the village that has never been outdone
Since the soldiers took their muskets to the war of 'sixty-one;
And a lot of lumber wagons near the church upon the hill,
And a crowd of country people, Sunday-dressed and very still.
Now each window is pre-empted by a dozen heads or more,
Now the spacious pews are crowded from the pulpit to the door;
For with coverlet of blackness on his portly figure spread,
Lies the grim old country doctor, in a massive oaken bed.
Lies the fierce old country doctor,
Lies the kind old country doctor,
Whom the populace considered with a mingled love and dread.

"Maybe half the congregation, now of great or little worth,
Found this watcher waiting for them when they came upon the earth;
This undecorated soldier, of a hard, unequal strife,
Fought in many stubborn battles with the foes that sought their life.
In the night-time or the day-time he would rally brave and well,
Though the summer lark was fifing, or the frozen lances fell,
Knowing if he won the battle, they would praise their Maker's name,
Knowing if he lost the battle, then the doctor was to blame.
'Twas the brave old virtuous doctor,
'Twas the good old faulty doctor,
'Twas the faithful country doctor—fighting stoutly all the same.

"When so many pined in sickness, he had stood so strongly by,
Half the people felt a notion that the doctor couldn't die;
They must slowly learn the lesson how to live from day to day,
And have somehow lost their bearings—now this landmark is away.
But perhaps it still is better that his busy life is done:
He has seen old views and patients disappearing one by one;
He has learned that Death is master both of Science and of Art;
He has done his duty fairly, and has acted out his part.
And the strong old country doctor,
And the weak old country doctor,
Is entitled to a furlough for his brain and for his heart."

6 East Franklin street.

REFERENCES.

[43]The Baltimore Medical College is the only medical school in this city which still administers the Hippocratic oath. It, however, is not infrequently read in the other medical schools at the introductory lectures.

[44]Instances of one pestilence seemingly preparing the way for another are given by Donaldson on pp. 99 and 100 of his "Review" as follows:

"In 5583 (A. D. 1579) the summer was very moist and rainy, succeeded by a cold, dry north wind about the rising of the dog star; the winter was open and chilling; an epidemic catarrh pervaded all Europe; in June it began in Sicily; in July it existed in Italy; in August it raged in Venice and Constantinople; in September it infested Hungary, Bohemia and Saxony; in October it prevailed on the Baltic; in November it appeared in Norway; in December it ravaged Sweden, Poland and Russia, etc. Its symptoms were a violent fever for four or five days, with pains in the head, straightness of the breast, a severe cough, terminating in profuse sweating. Bleeding and purging, says Reverius, were considered injurious in general. In Rome 4000 persons died of it; in Lubec, 8000; in Hamburgh, 3000, and great multitudes in other places perished by epidemic pestilence. While this deadly catarrh wasted Europe, one of the most destructive plagues ever known began in Grand Cairo. Prosper Alpinus, who lived in that century, has reported the number of deaths from November, 5584 (A. D. 1580), to July, 5585 (A. D. 1581), to have been 500,000. It has been always observed by us that epidemic anginas, quinsies, smallpox, measles, catarrhs and fevers generally precede great and dreadful plagues, as their precursors; for the constitution of the seasons to produce these diseases being continued and increased in its natural or accidental malignancy and powers, will always induce pestilence or plague, as the highest gradation of morbidity in all these distempers which appear to be the same in essence, but different in appearance, only modified by the differences of climate, differences of the seasons, and the differences of the duration and energy of the efficient causes. It carried off in the same year many hundred thousand persons of the poorer class of the population of France and Egypt; it prevailed especially at Laon, in Vermandois, which is much exposed to the burning heat of the sun, and destroyed 6000 persons. The historian Thuanus relates that the crops of that year were plentiful and the sky serene, but he does not tell us the duration of the drought, the gradation of the heat, the suddenness of the changes of temperature, the heat of the days and the cold dampness of the night. The catarrh in those days was distinguished by a chill, or rigour in the lower portion of the spine, which was succeeded by gravedo or dull pain in the head, languor, universal dejection of spirits, and diminution of strength; and when it did not end favorably in five days, it terminated in a fatal fever."

[45]The colonists landed at St. Mary's March 25, 1634, the anniversary of which date we still celebrate as "Maryland Day."

[46]We cannot protect man too well from communicable diseases. Yet, as a rule, those in authority are loth to spend money for such a purpose. Ample provision, however, has been made to protect cattle from tuberculosis, hogs from cholera and swine plague, horses from meningitis, sheep from anthrax, etc.; and the casual

reader is sometimes half inclined to believe there is a modicum of truth in the oft-quoted story concerning the tuberculous mother and the cholera hog, whose moral is, "Be a hog and be worth saving." This is all a mistake, because, in the language of poesy,

"Man is the noblest growth our realms supply,
And souls are ripened in our Northern sky."

[47]Dr. Rush, writing of the influence of a single epidemic upon diseases prevailing at the time, or of the influence of epidemics over each other, makes the following statement on p. 89 of his work on yellow fever:

"The bilious remitting fever which prevailed in Philadelphia in 1780 chased away every other febrile disease, and the scarlatina anginosa which prevailed in our city in 1783 and 1784 furnished a striking proof of the influence of epidemics over each other. In the account which I published of this disease in the year 1789 there are the following remarks: 'The intermitting fever which made its appearance in August was not lost during the month of September. It continued to prevail, but with several peculiar symptoms. In many persons it was accompanied by an eruption on the skin and a swelling of the hands and feet. In some it was attended with sore throat and pains behind the ears. Indeed, such was the prevalence of the contagion which produced the scarlatina anginosa that many hundred people complained of sore throats, without any other symptom of indisposition. The slightest exciting cause, and particularly cold, seldom failed of producing the disorder.' ('Medical Inquiries and Observations,' London, edit., Vol. I, p. 122.")

[48]This humanitarian spirit in physicians is beautifully alluded to in the following quotation from Dr. R. L. Howard's introductory lecture entitled "The Shame and Glory of the Medical Profession," delivered before the Starling Medical College of Columbus, Ohio, on the evening of November 7, 1849:

"Since the medical profession has been thoroughly organized within the last few centuries, whenever any widespreading pestilential calamity has prevailed, when men, women and children by thousands have been swept away as with the besom of destruction by smallpox, plague, yellow fever, or the devouring cholera, who hath stood at his post, jeopardized his own life and braved every danger in order to save or soothe the perishing victim? Though the night be dark, cold and stormy, and the tempest drives its fearful career over the dreary earth, who arises at any and all hours, answers to the call of the poor as well as the rich, the lowly as well as the honorable, the ungrateful vagabond as well as the grateful and cherished friend, and finds his way to the bedside of the sufferer? Let the community answer. We know and confess with shame and indignation that there are dishonorable exceptions to the general rule. We know that there are those among *us* who fled through sheer cowardice from the cholera and scenes of distress and danger. As they deserve, let the *"anathema maranatha"* fall upon their heads. They are traitors to our order, false to their profession, their fellow men, and their God."

[49]Commenting upon the high type of bravery exhibited by physicians in times of deadly epidemics, and the little notice which their heroism receives, Dr. Rush, on p. 339 of his book on yellow fever, has the following to say:

"Narratives of escapes from great dangers of shipwreck, war, captivity and famine have always formed an interesting part of the history of the body and mind of man. But there are deliverances from equal dangers which have hitherto passed unnoticed; I mean from pestilential fevers. I shall briefly describe the state of my body and mind during my intercourse with the sick in our late epidemic. The account will throw additional light upon the disorder and probably illustrate some of the laws of the animal economy."

Dr. Rush then follows with a lucid account of his own labors and sufferings, which extends through twenty-five pages.

[50]Will Carleton died at his home in Brooklyn, N. Y., of pneumonia on December 16, 1912, aged 67 years.

ADDENDA.

1. Since the first part of this article was written Dr. Benjamin F. Shipley, health officer of the Third District, Howard County, has died, at the age of 64 years. His death occurred on June 13, resulting from mitral insufficiency and cardiac dilatation, following a severe attack of influenza. He was succeeded by Dr. John W. Hebb of West Friendship.

2. In checking up the monthly reports of typhoid fever for 1912, a discrepancy of 98 cases of sickness was detected in the figures for the month of October. Adding these to the 1697 cases given in reference No. 41, makes a total of 1795 typhoid cases, and a grand total of 5825 cases of communicable diseases, instead of 5727. By including the 522 county tuberculosis cases, the

total for the year is increased to 6347. (See Annual Report of the State Board of Health for the year 1912).

3. Since writing the foregoing paper a copy of the "Annotated Code of the Public Civil Laws of Maryland," edited by George P. Bagby of the Baltimore Bar, was purchased by the State Board of Health. But I wish to explain that I have followed the old code—that of 1904, the "Public General Laws of Maryland," codified by the late Hon. John Prentiss Poe.

## Correspondence.

### SCHOOL FOR HEALTH OFFICERS, CONDUCTED BY HARVARD UNIVERSITY AND THE MASSACHUSETTS INSTITUTE OF TECHNOLOGY.

Beginning this fall, Harvard University and the Massachusetts Institute of Technology are to maintain in co-operation a School for Public Health Officers. The facilities of both institutions are to be available to students in the School, and the Certificate of Public Health (C. P. H.) is to be signed by both President Lowell and President Maclaurin.

The object of this School is to prepare young men for public health work, especially, to fit them to occupy administrative and executive positions such as health officers or members of boards of health, as well as secretaries, agents, and inspectors of health organizations.

It is recognized that the requirements for public health service are broad and complicated, and that the country needs leaders in every community, fitted to guide and instruct the people on all questions relating to the public health. To this end, the instruction of the new School will be on the broadest lines. It will be given by lectures, laboratory work, and other forms of instruction offered by both institutions, and also by special instructors from national, state and local health agencies.

The requirements for admission are such that graduates of colleges, or technical and scientific schools, who have received adequate instruction in Physics, Chemistry, Biology, and French or German, may be admitted to the School. The medical degree is not in any way a pre-requisite for admission, although the Administrative Board strongly urges men who intend to specialize in public health work to take the degree of M.D. before they become members of the School for Health Officers.

The Administrative Board which will conduct the new School is composed of Professor William T. Sedgwick, of the Massachusetts Institute of Technology; Professor Milton J. Rosenau, of Harvard, and Professor George C. Whipple, of Harvard. Professor Rosenau, of Harvard, has the title of Director, and the work of the School will be under his immediate supervision.

# MARYLAND MEDICAL JOURNAL

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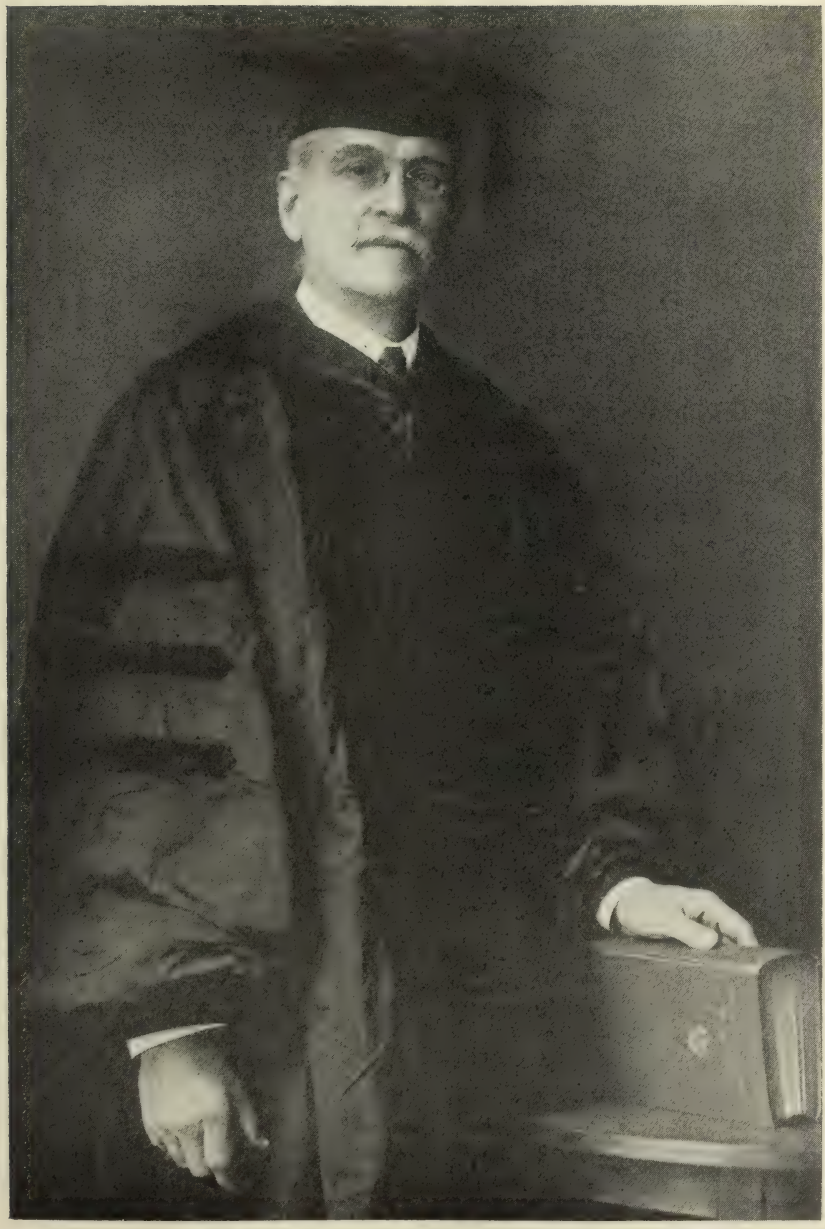
BALTIMORE, OCTOBER, 1913


## THE LATE EUGENE FAUNTLEROY CORDELL, A.M., M.D.

The sudden death of Doctor Eugene Fauntleroy Cordell, August 27, 1913, a former editor of the MARYLAND MEDICAL JOURNAL, has removed a unique figure from the medical profession of Maryland. His most valuable legacies undoubtedly have been his unselfish devotion to philanthropic efforts in behalf of those left helpless and his rescue from oblivion of the life, acts, deeds and accomplishments of Maryland medical genii of bygone times. His chief delight and happiness were in doing in a modest and unassuming way something for those in destitute circumstances. The widows and orphans of those physicians to whom he lent a helping hand, and, better still, sympathy in their loneliness and desolation, will sorely miss his cheerful smile and words of hope and encouragement. In order to better care for these unfortunates he founded and financiered The Home for Widows and Orphans of Physicians. Among his other philanthropic efforts in which he took especial pride are the creation of a fund for widows and orphans of physicians, the establishment, together with Doctor Leigh Bonsal and Mr. George Torrance, of the Home for Incurables, and the creation of a permanent endowment fund for the University of Maryland. Doctor Cordell was a man of many noble qualities, a steadfast friend, a firm believer in and supporter of high medical educational standards. He was thoroughly convinced that the doctor should be an educated man, and as a result of this belief, called together the representatives of the Baltimore medical institutions, through which meeting the Association of American Medical Colleges directly resulted. He was a man of the highest ideals, and spoke out his convictions without a least regard of personal consequences. There has never been, and in all probability never will be, another such man in the profession in Maryland. He devoted his life to man, untiringly, ceaselessly, unselfishly giving the best years and efforts of his life to the helping of others. He was an authority on the his-



EUGENE F. CORDELL, A.M., M.D.
1843-1913.

tory of medicine, and especially versed in that of Maryland, and was a prolific writer along these lines, for which services posterity owes him an everlasting debt of gratitude. His Medical Annals of Maryland and Histories of the University of Maryland are priceless heritages which will perpetuate his name as long as our profession exists. Unfortunately, he did not live to see his work fully materialize. But he may console himself with the thought, "We find an unfinished work when we arrive; we leave the work unfinished when we are called hence." Each day marks out our duty for us, and it is for us to devote ourselves to it, whatever it may be, with high purpose and unfaltering courage. Whether we live to enjoy the fruits of our efforts or lay down the work before the victory is won, we know that every well-spoken word has its influence; that no good deed is ever lost. And we know also that no one can count his life on earth as spent in vain if, when he departs, it can be said: "The night is darker because his light has gone out; the world is not so warm because his heart is grown cold in death." Judged by this standard, Doctor Cordell cannot count his life as spent in vain. Though some of his dreams have not fully materialized, he has created a sentiment, and some strong man or woman will take up the tasks which he was so unexpectedly called upon to relinquish. As soldier, physician, historian, teacher, writer, moralist, he sustained his various offices with the approbation of his fellow-man, while he illustrated in his life those graces which adorn the Christian character. He had no patience for the hypocrite, but endeavored to be absolutely fair in his writings by giving credit to whom credit was due. He was exceptionally keen in his estimates of men, a simple, guileless soul, bent on doing his duty as he saw it. Though extremely religious, he never intruded his religious views upon others. No one surely was better prepared to meet the call of his Maker and with better grace answer, "Lord, I come." While living he exemplified by his every act those glorious words of Oliver Wendell Holmes:

"Build thee more stately mansions, O my soul,
As the swift seasons roll;
Leave the low-vaulted past;
Let each new temple, nobler than the last,
Shut thee from heaven with a dome more vast,
Till thee at last are free,
Leaving thine outgrown shell by life's unresting sea."

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## PRESIDENT'S ADDRESS

### AMERICAN THERAPEUTIC SOCIETY.

MAY 5, 1913.

*By Noble P. Barnes, M.D.,*
Washington, D. C.

GENTLEMEN OF THE AMERICAN THERAPEUTIC SOCIETY—It is perhaps superfluous for me to express my profound appreciation of the distinguished honor that has been conferred upon me by this society, America's representative of advanced therapy. Seemingly, it would be a grievous error if left to the unwritten understanding.

Realizing the exalted position is not a lone feeling of satisfaction, for the president of a national organization like this is all the more "a debtor to his profession," and is deeply sensible to the associated responsibilities. This occasion of supreme attempt is, therefore, approached with hesitancy, even timidity, when, reflecting for a moment, I recall the celebrities in whose shoes I am standing, if not filling, today—Wood, Wilcox, Satterthwaite, Barker, Osborne, Beck, Reyburn, Shoemaker, Gerrish, Wilson, Wiley and Blackader.

My thirteen years as secretary to this society have been a great schooling; an annual post-graduate course of new therapy six to twelve months in advance of the press. This and another selfish reason are my excuses for inflicting my services for so long a period.

There is a sense of delight in meeting and rubbing shoulders with and knowing great men, but there is a greater satisfaction in having them know you. A secretary is always known, possibly not always pleasantly, but he is known; therefore my second excuse. Rewards today realized are a greater measure then, than my meagre efforts deserve, and must be regarded, at least in part,

an expression of respect for my colleagues, the local members, who have likewise contributed to the success of the Washington meetings of the Society.

To read the programs of the scientific sessions of the American Therapeutic Society is to review the advances in the practical and most important branch of medicine and surgery in a period of time that has outstripped the accumulation of all ages in scientific attainments; resulting not only in the greatest relief for the individual patient, but the broader conception; the prevention of disease and the care of the public health.

Therapeutics of today is not an art, but a collection of facts, scientific or empirical, and the latter are passing through the furnace of scientific proof. The instruments of precision and investigation that made histology, physiology, bacteriology and pathology have now entered the field of therapeutics. These scientific studies have given us our chemotherapy, our serums and our vaccines, the action of which only a few years ago would have been miracles.

The entire scope of accurate therapy co-ordinates with scientific results that can be prognosticated. The old blind unreasoning faith in the mysteriously wise physician is gone, and through thoughtful reasoning and accurate deductions, we have passed into the spotlight of science, with corresponding death-rate reduction, diminished infant mortality and lengthened span of life. The remnants of fanciful theorizing and superstitious faith are nowadays seen only in cults and pathies born of ignorance and nourished by selfish imposition of the unscrupulous on the still ignorant.

Until recently the general profession was several years in arrears of advanced medicine, and the people several years behind the general profession. Notwithstanding the advancement made, it is yet an interesting fact that the professional ability of a predecessor can be accurately gaged by the family's knowledge and application of the principles of health and hygiene.

It is needless to remind you that a few decades ago there was little scientific therapy; that the organizing of The American Therapeutic Society was for the purpose of giving life to the important excuse for our professional existence, the treatment and prevention of disease.

Need I remind you that our drug armamentarium was in a questionable condition; that our pharmacies were surfeited with proprietaries, and that so-called synthetics and new combinations were strangling all attempts at rational drug therapy?

Need I remind you that one of the first acts of this Society, May 2, 1900, was to present a plan to the Pharmaceutical Convention, then in session, relative to the forming of a bureau of materia medica investigation? This plan a month later was presented to The American Medical Association, and finally culminated in the establishing of a Council on Pharmacy and Chem-

istry, which, together with efforts of a similar department of the government, has accomplished inestimable good for both layman and physician.

Need I to remind you that in order to systematically tabulate the progress in therapy a method was first instituted in our New York meeting of 1902 to review the advances in various branches? This suggestion was soon adopted by leading societies and journals all over the world. Live again for a moment that inaugural symposium with D. B. St. John Roosa, William H. Carmalt, Charles H. Knight, Eugene Fuller, Charles G. Kerley, Ed. D. Fisher, Mathew D. Mann, Charles Jewett, Newton M. Shaffer, William J. Morton and Charles W. Allen.

Need I to remind you in another year we had taken up the important subject of the teaching of therapeutics, and the equally important proposition of drug standardization? Still another year and we have a survey of advances in anesthesia, that stands in advance to this day, and the study of combat with infection given by an equally strong array of talent.

Symposia, on Diseases of the Vacular System, The Treatment of Tuberculosis, on Roentgen Ray Therapy, on Diabetes, on Cholelithiasis, on Diet, on Psychotherapy, on Matters Pertaining to the Revision of the Pharmacopœia, and lastly on the Etiology and Treatment of High-Blood Pressure, have been presented by men of advanced thought and authorities on their respective subjects.

Likewise every form of therapy, from chemical to mechanical, from physical to psychical, from curative to preventive, has been presented by a score of experts. Papers on metabolism anaphylaxis, immunity and every phase of advanced medicine and surgery have entered into the varied, interesting and instructive programs.

It was, indeed, a happy time for the birth of a therapeutic society that was to live in, and to assist in, the development of modern scientific medicine.

In this day of The American Therapeutic Society we have traveled from the discovery and understanding of many pathogenic bacteria, the etiological factors in many diseases, their means of invasion, their hosts, their life and habits and the measures to employ to prevent or neutralize their existence, to the benevolent organisms, and their employment in combating disease and deferring old age.

We have come to realize that these lower forms of life, hitherto impenetrably shrouded, have, through their influence on man, actually ruled the universe from all time. Good or evil government, health or disease, strength or weakness, depending entirely upon the opposing forces; the beneficent or malignant microbes constantly at war in the human body.

The triumph of health over disease is an understanding of these. We no longer wait for the deadly microbe to intrench

and mass, but anticipatingly defend by immunizing. Thus have the scourges smallpox, lockjaw, typhoid, diphtheria and hydrophobia succumbed to science.

This modern conception of disease, its causes and prevention, has made health resorts out of previously diseased and death-ridden districts. It has enabled our armies to be massed without having hundreds die of disease to every one killed in battle. It has permitted the completion of the greatest engineering feat of modern times. It has enabled Stiles and his co-workers to overcome the insidious worm of laziness. It enabled Surgeon General Blue and his force to prevent recently the spread of cholera and the bubonic plague. It enabled McLaughlin to understand the cause of infant mortality where the mothers were living on foods lacking in nitrogenous element. It has enabled the hygienic labratory to prepare rabies antidote, not only for cases that come here for treatment, but for those applying for treatment at the health departments in any part of the country. It has given pure water and pure milk to the community. It is hopefully wrestling with pellagra, cancer and other diseases not yet surrendered.

Never in the history of mankind has there been a period of time so replete in activities for lessening disease and accident, preventing mental and physical suffering, and contributing to the happiness of the whole people.

This is truly the age of the gospel of health and hygiene. Results are already apparent. The health office report for 1912 announced the lowest death rate ever known in the District of Columbia. In two decades death from typhoid was reduced more than 66 per cent.; from tuberculosis over 33 per cent. We now count on a span of life about ten years more than the allotment of 1900.

It requires restful reflection to realize the changes in modern life resulting from recent scientific medical discoveries. The practical application of these have made it possible for masses of humanity to live in comfort and health where overcrowding was formerly penalized by death. The whole scheme of modern life is built around modern sanitation, the removal of which would cause our modern cities to shrivel with a promptness that would fade into significance the pestilences and plagues of the past.

While in harmony with all methods of public education that are conducted along rational lines, I cannot refrain from calling your attention to this swift-moving age, with its thirst for individual aggrandizement and notoriety. The classic can now be changed to read,

"Lives of great men all remind us
We can make our lives eternal
Without departing, have beside us
Four-inch headlines in the JOURNAL."

In this day we have movements, founders, organizers, expounders, professional philosophers and general disturbers of the peace. We have a multiplicity of authority on education, social

order (or disorder), moral (or immoral) hygiene, political economy, international diplomacy, cattle, cats and children. There are some real artists in this line who get money, it is claimed, for every word they write, and there seems to be no limit to the writing. Some good, some bad, some dangerous.

The anxious mother, who has a dyspeptic and unnatural child, or a normal one, for that matter, must feel a sense of relief when she shifts the responsibility of the child's diet and living to the guidance of a dietary expert, who boldly states that the child may select his own diet, and there shall be no argument about it, for "he wants what he wants when he wants it." This, "like the love of God, passeth all understanding."

In this education and re-education of mankind there is evidence of the general wave of hysteria that has spread over the world. Here are two men writing on the same subject—"Care of the Skin," etc. One is enthusiastic over soaps, listing a sufficient variety to arouse suspicion; the other decries its use, and belittles the mind still clinging to the delusion.

Here is another man, remotely removed from the New York subway, who believes that agitating the air, no matter how confined, the currents produce the desired degree of freshness.

Still another interesting suggestion, novel enough for notice, comes from a French educator, Dr. Leon Meunier. He claims that walking on all fours after a meal is the best means to expedite gastric evacuation. There will be opportunity for the members to confirm this statement during this meeting. To walk around the tables in this manner may appear unprofessional and undignified, but why object so long as the right education is being given to an organ that shows a rebellious spirit during occasions of this kind.

Then we have the mushroom sex educators, often perverts, with their "important messages to parents." If there was ever a day when a child needs our deepest consideration that day is here. Such a bombardment of advice has never before been directed against the helpless innocent. Here is a book on "How to Train the Young," "What Should a Girl Know?" "What Should a Boy Know?" etc. Some of these books are good, some excusable, some devoid of sense and abounding in suggestion. Some the products of spinsterhood, some the expiring efforts of masculine senility. Pity the child who falls victim to these hysterical effusions.

The influence of the press on the evolution of the people is an important and serious matter. More attention should be given to the medical items that are sometimes handled in a careless manner. The people have a right to receive accurate statements, and the editors are anxious to supply the public demand. Misrepresentation may occur when an enthusiastic reporter desires to supply an interesting news item; more often the error is the

result of the effort of some self-appointed educator to air his name and address, and frequently his cure.

The greater the interest in subjects pertaining to health and hygiene the better for preventive therapeutics. Therefore, any means of disseminating medical knowledge that is correct and proven, that eliminates the undesirable and the untrue, is proper. No vehicle can carry this burden better than the daily press.

A presidential address should contain at least one suggestion, even if it be but the "two grains of wheat hidden in two bushels of chaff." Therefore, your indulgence for a few minutes to discuss briefly a subject that has, I dare say, been in the minds of every thinking physician since his college days.

Hosts of students are so confused in their study of pharmacology, so drowned in the enormity of its propositions, so discouraged in the monotonous memorizing of the meaningless mass that they fail to collect and retain the wheat, and in due time become drug nihilists or thoughtless prescribers of proprietaries, replenishing their forgotten studies with the dictum of some manufacturing pharmacist, who enlightens them with all the brand-new therapy published in an advertising sheet with a big-sounding name at a dollar a year, and a clinical thermometer thrown in, "Make it two, and receive a leather pocket case with our specific drugs."

Many other men absorb a great amount of materia medica, and are clever at prescription writing in the second year, but the clinical staff, educated in the old way, slights therapeutic application, fits patients to numbered combinations, and the labor of a year is lost. If the clinician prescribes nostrums, what can be expected of the young graduate? He naturally becomes a thoughtless, indifferent prescriber of the "elegant pharmaceutical preparations" of which he knows nothing except what he gleans from the manufacturer's literature, "a highly-colored expression of printers' art," and he proceeds to medicate accordingly. Can drug therapy advance under these conditions?

These shortcomings might have been, to some extent, attributed to our lack of exact facts in the past, but today we have enough facts to make a perfectly rational teaching materia medica. It is the amount of facts and knowledge a physician uses that makes his work successful. Inert agents, misapplication and faulty technique make a failure of the best of them.

If we but teach and practice with the absolutely proven drugs, materia medica and drug therapy would be placed on a sound and rational basis.

The American Therapeutic Society has a duty to perform right here in preparing and presenting to the teachers and examiners a properly limited materia medica with a rational, scientific classification. This will at once give influence and impetus to a successful, scientific drug therapy.

In the first place, only drugs of indispensable value and, so far

as practical, chemically assayed or physiologically tested should be admitted. The manufacturing chemist and pharmacist, and the physiological laboratory man, can supply us with drugs of known purity and strength, giving us dependable products, properly selected, properly manufactured, standardized and properly marketed and properly dispensed.

This accurate knowledge of the important drugs will soon restrict the multitude of recognized and unrecognized remedies, give better control and better quality to these remedies, and enable the student to master everything concerning the selected drugs from pharmacognosy to pharmacodynamics, everything from solubility to incombatibility, everything from methods of administration to variances in action.

As stated in the special article of the A. M. A., "The Pharmacopœia and the Physician," Chapter XVIII, "The use of the term is often an admission of our want of exact knowledge of the mode of action of the drug or remedies so classed." An illustration of this is given in Chapter XX, "Alteratives are tonics, which in some unknown way favorably influence the process of nutrition which has been disturbed by disease." Now, if the use of mercury as an alterative is most apparent by its influence on the spirocheta pallida, why is it any more of an alterative than quinine in its application to the plasmodium hematozoon when the latter has been classed as a tonic and antiperiodic?

Chapter XVII takes up "Circulatory depressants, beginning with "The circulation may be depressed by acting on those structures the stimulation of which causes an increase in blood pressure," an accidently erroneous statement. But why this uncertain, unthinking classification? The present-day teaching and textbook classification, with few exceptions, throw small light on the practical application of scientific drug therapy. The continued use of the old classifications, such as tonics, alteratives, antiperiodica, emmenagogues, etc., are with our modern understanding, to say the least, reactionary, if not ridiculous.

This teaching materia medica, with its rational classification to be authentic and conclusive, must bear the stamp of approval of the majority of our membership. Not wishing to be regarded as underestimating any plan the Society is now undertaking to advance therapeutics, I believe the plan here suggested would be of infinitely more lasting benefit to the profession at large. Giving the teacher and pupil a materia medica of proven drugs in a classified manner that will develop the reasoning rather than the memory machine, a synopsis that could be elaborated by the textbbook writers and used as a guide by state board examiners, is a plan the accomplishment of which will put drug therapy on a lasting, rational, scientific basis, create delight and gratitude in an overdrugged profession and student body, and reflect lasting credit upon The American Therapeutic Society.

# CANCER FACTS FOR THE LAITY.*

*By Alexius McGlannan, M.D.*

THE experience of all competent observers teaches that the only sure cure for cancer is early and complete removal of the growth by cutting it away from the patient with a sharp knife. All other methods of treatment are uncertain, more painful, or only palliative. Until the real cause of cancer is discovered no treatment, except surgical operation for its complete removal at the earliest possible time, can be considered or recommended.

The life of a cancer may be divided into three stages—first, the time during which the presence and growth of the tumor do not attract the attention of the person harboring it; second, the time the patient allows to pass before seeking the advice of a physician; third, the time consumed by the physician in making a diagnosis. The second period is the one which we hope to shorten by such talks as this. The first period cannot be altered, and, as far as our experience goes, the number of cases in which a cancer becomes incurable during this period is small. The duration of the third stage rests with the efficiency of the medical profession, a matter in determining which you have a decisive voice and an opportunity for selection. Remember that your best adviser and real friend is your family physician; remember, also, that his greatest interest and reward rest in your prompt recovery from every illness. Do not spend your money, therefore, and risk your lives and happiness in consulting quacks.

No man possessing a non-operative cure for cancer need spend a cent for advertising in newspapers. All over the world men of the highest intelligence are devoting their lives to the study of cancer for the purpose of learning its cause and thereby discovering a method for curing and preventing it. To the man who discovers this cure the world will pay untold wealth. The amount of money he could make would be limited only by his desire for making it. He would tell his discovery to all the medical profession freely and without reserve of any kind. And yet from every country the very rich would seek him out, pay him any price he demanded, and make his income whatever he charged multiplied by the number of patients he cared to treat. Isn't it absurd, therefore, to even think that a man possessing this knowledge should conceal it as a secret and spend thousands of dollars for newspaper and other forms of advertising in order to attract patients? That he should flee from State to State, and, transacting business under first one name and then another, live in constant fear of punishment for using the mails to defraud and for other crimes of a similar nature? The truth is, that the cancer quack, the man who advertises or promises to cure cancer by any means other than

*Address delivered under auspices of Committee on Public Instruction of the Medical and Chirurgical Faculty.

by surgical operation, is a fraud, a liar, a heartless, scheming villain of the most cruel of all types, and that he knows he is all these things, but attempts to befog investigation of his villainy by an attack on the real medical profession, by a cry for liberty and relief from oppression.

Every robber feels that his liberty is imperiled and himself oppressed by the activity of the police. But we do not pass laws to allow robbers the right to rob. This is really what the association of quacks and patent-medicine manufacturers, posing as a League for Medical Freedom, asks you to do.

To return to our subject: The duty of the patient is to consult a reputable doctor as soon as any sign of cancer shows itself. This leads at once to the question, What are the signs of cancer? Most cancers seem to develop from a previously existing condition, which we call a precancerous lesion. If all these precancerous lesions could be removed by operation or otherwise, no cancer could develop and no extensive operations would be required.

For you the important signs of cancer and precancerous lesions are as follows: A lump in the breast of any woman over 30 years of age, in 95 per cent. of all cases, is cancer, or will become cancer if not operated upon. Under 30, a single lump is not so likely to be cancer, but, however, is very likely to become malignant when the woman becomes older. Multiple lumps in the breast of a young woman are seldom malignant.

Any irregular bleeding or discharge from the womb may be a sign of cancer. This is especially true of profuse menstruation and of bleeding between the monthly periods. Any woman having such bleeding should lose no time in being carefully examined for cancer of the womb. Practically all of the hopeless and incurable cases come to the surgeon after months or years of neglect of this simple precaution.

A hard lump or a persistent sore on the lips, tongue or lining of the mouth, especially when situated opposite to a rough tooth, is a precancerous lesion. Scabs and running sores on the face and hands, little rough discolored areas on the skin anywhere, growing warts and moles, especially those appearing after 30 years of age, or those that have been injured or bleed easily, are all precancerous lesions, easily cured if taken early. Any wound that does not heal promptly may be an evidence of cancer.

Cancer of the stomach and of the bowels are common, and if taken early give the best outlook for cure by operation. Their symptoms, however, cannot be clearly described to a non-medical audience, but do not drug yourself for dyspepsia and constipation. Consult your doctor and have him make the necessary examination to prove your freedom from cancer.

Some explanation must be made of the limitations of surgical operation for the cure of cancer and the value of certain non-operative remedies much talked about at the present time.

Cancer spreads first by direct growth in its original situation,

next by sending its cells (seeds) to the lymphatic glands, which swell and resemble the so-called waxen-kernel, and, finally, the cancer cells are carried by the blood to all parts of the body. As long as the cancer is limited to its original seat, if the seat is in an organ or part not essential to life, 90 per cent. of cases of the disease will be cured by removal of this organ or part and the adjoining lymphatic glands and channels. When the cancer has spread to the glands the chance of cure falls to about 25 per cent., and when it has gone farther the disease is incurable.

Sometimes a patient comes to us in the incurable stage, but with a distressing local condition demanding relief. We must operate to give the patient relief for the rest of her life, and we do so, clear in our own minds as to the hopelessness of cure; but, unfortunately, the friends and neighbors of the patient will not understand this fact, and when the inevitable fatal end comes they unreasonably charge the failure to the inefficiency of surgery instead of to the procrastination and delay that made the condition hopeless before relief was sought.

Studying these hopeless and late cases, we find that the body makes an attempt to overcome the spread of cancer by building up walls of dense scar tissue into and around the tumor wherever the growth of the cancer cells is lessened in vigor. Any form of treatment that increases the growth of scar tissue is useful in relieving these patients by limiting the local growth. It is in these cases that caustics, X-ray, radium, etc., have their value, but their use must be limited to the treatment of this group of cases.

A curable cancer means one curable by a cutting surgical operation, and the use of any other form of treatment is unjustifiable and indefensible, because such treatment wastes valuable time, makes an interval during which the cancer may spread by means of the routes mentioned above, thus reducing the chance of cure to almost one-fourth, if not making it absolutely impossible.

Radium, X-ray and chemical caustics act exactly as does the hot iron or the electro-cautery by destroying the vitality of the cancer cells and stimulating the growth of the scar tissue wall. They can act only on the local growth and only on that part of it with which they come in contact. Therefore, they cannot retard the spread of the disease, and cannot cure the patient.

All of these facts are well established by the study and statistics of workers in many places. All the large surgical clinics contribute the same report and request, namely, send the cancer patients for operation earlier in their disease. Institutions like the Cancer Research of Great Britain, where thousands of cases have been studied; like the Cancer Institute of Germany and similar laboratories and institutions all over the world, give out the same information.

There is no specific cure for cancer; its cause has not been discovered; the hope of its victims lies entirely in early and complete eradication by surgical operation. There is no value in any other

form of treatment. The first operation seals the fate of the patient. An incomplete operation in the early period will give worse results than a complete one for the same tumor performed at a later time. Therefore, every patient has the opportunity for seeking cure at the hands of a competent surgeon, no matter where he or she lives, and, of course, without regard to his or her financial condition. This last point is the real acid test to distinguish between the true physician and the quack. Has anyone ever known a quack to treat without pay all the poor who came to him? Has anyone ever known a competent surgeon to refuse to give his best efforts and to do hard physical work in operating for the cure of cancer? Although so many ungrateful patients have made this altruistic devotion to duty both unpleasant and expensive for the surgeon, the test holds good, and no person need suffer from cancer because of lack of money to pay for surgical operation.

114 West Franklin Street.

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# ON THE DESIRABILITY OF NATIONALIZING THE BALTIMORE QUARANTINE STATION.*

*By J. A. Nydegger, M.D.,*
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I presume I have been requested to discuss the question of the transfer of the Baltimore Quarantine to Federal control, because, like all who are in the Service, I have had some experience in quarantine work and administration. On this occasion, however, I am prouder of something else, and that is that I am a Marylander, and am here as a Marylander to take part in this discussion with you; and so anything I may say on the subject of quarantine this evening will be with the best interests of the State of Maryland and the city of Baltimore at heart.

Quarantine is a big subject, and in the time allotted for the discussion one can refer but briefly to a few points in passing.

From 40 days' detention in quarantine (as the word quarante implies) of vessels and their personnel arriving from infected places, down to 20 days' detention in quarantine, as was ordered by President Harrison in 1892, when cholera-infected ships lay in New York harbor, and the country was threatened with an invasion of this dread disease, and great fear existed throughout the land lest it should gain a foothold, is a great reduction in time. It is also a long cry from the middle of the fourteenth century, when Venice first put into use in Europe a quarantine against epidemic diseases coming from the East along the lines of mari-

*Address delivered at the meeting of the Baltimore City Medical Society, May 16, 1913, by invitation.

time commerce, down to the twentieth century, with its management of modern quarantine.

From 20 days' detention in quarantine in 1892, down to five days' detention in 1913, of suspects and contact cases of cholera, with disinfection and immediate release of the vessel, is another great step forward. This is the result of science—the result of the application of science—the use of knowledge derived from the scientific study and observation of diseases, applied, first, for the protection of the country from the invasion of highly-contagious diseases, and, second, for the assistance and expedition of maritime commerce, and not as a detriment to it.

Surely the word "quarantine," as originally applied, is now a misnomer, and a new name more in keeping with the modern and scientific administration of quarantine might well be sought for.

Dr. Ford has spoken in a most interesting manner on the history of quarantine, and has pointed out the tendency which has existed from time to time since quarantine was first put into effect to make it uniform, not only in a city or country, but throughout all the leading countries of the world. He has also pointed out that there were important commercial reasons for this; and that as health, quarantine and commerce have been so intimately connected in the past, so they will be in the future; and to that end the wise Colbert, in France, under Louis XIV, in the seventeenth century, first promulgated the order that took from the many cities and local boards of health, which maintained each a different set of quarantine rules and regulations—the period of time vessels were quarantined depended wholly on the whim of the boards, with great inconvenience to commerce—and gave the first general sanitary regulations for the whole of France, thus putting the government above the *province* and the *city,* and establishing the fact that maritime quarantine is of national importance, and a function to be conceded to the *nation.*

A great step forward in the application of quarantine throughout Europe and Asia was when the first International Sanitary Conference was held in Paris in 1851, attended by the representatives of the 12 leading European and Asiatic countries most actively engaged in maritime commerce, and the preparation of a code of more scientific quarantine measures to be enforced uniformly at the ports of the nations represented, which paved the way for future congresses of this kind, at which the administration and scientific principles and policies of modern quarantine were laid down; and in the early part of the twentieth century (1903), at the congress in Paris, 20 leading powers, including the United States, signed what is known as the International Sanitary Agreement for uniform quarantine rules and administration; but, mark you, gentlemen, the *United States is the only country subscribing to this agreement,* which cannot guarantee to the 19 other countries that these rules will be the only rules binding the whole country. Why is this? I will show later on that the United

States, of all these 20 countries, is the only country which has not control of all the quarantine stations on her shores. In the 19 other countries included in the agreement the matter of maritime quarantine has long since been recognized as being pre-eminently a function of the general government, and was accordingly transferred to it. The development of quarantine in European countries has been practically duplicated by the development of quarantine in the United States. The development of quarantine in European countries has been intimately connected, through maritime commerce, with our own, and ours has been developed and extended along similar lines.

In colonial times the different Legislatures had control over the quarantines, a power which was inherited by the States and municipalities, and is still exercised by them in the ports of New York, Boston and Baltimore, although all other ports by this time have come under national control.

After the first sanitary conference held in Paris, in 1851, it became evident that the non-uniformity of the laws regulating quarantine in the different States of this country not only caused great inconvenience to freight and passenger traffic, but was a positive menace to public safety. Some ports, for the purpose of attracting commerce, would be lax in following the strict regulations which they had imposed on themselves, while others would make mild regulations with the same object of getting trade, thus frequently admitting epidemic diseases.

A grave situation or crisis is sometimes a blessing in disguise, and although resolutions had been passed in a conference of delegates from all the ports of the United States, held in Philadelphia in 1856, and twice subsequently, in an effort to establish the desired uniformity, no legislative action followed; and the grave cholera situation in New York harbor in 1892 resulted in an investigation of the New York quarantine and its relation to the Federal Government service on the part of the New York Chamber of Commerce. These investigators found that New York was not able to cope single-handed with the situation, and consequently declared themselves emphatically in favor of Federal control, giving as their reason that as the Federal Government is an indispensable factor in every quarantine crisis, it is better to have the Federal Government directly, instead of indirectly, responsible, and to that end all quarantine stations should be under national control, and not under municipal or State authority.

The New York Chamber of Commerce, working in conjunction with the New York Academy of Medicine, composed of 1000 members of the medical profession, many of whom stand at the very top of the profession in this country, prepared a bill in favor of a national system of quarantine control, giving as the chief reasons the insufficiency of the State or municipality for dealing with the emergencies confronting them, with special reference to New York city, and pointing out that the interests which center in a

port are not *solely* nor *largely* local, but national, and expressing the belief that the establishment of a national system could be most surely made humane, prompt and efficacious by reason of the large and varied resources, both in trained men and material, which would be available, the power of rapid concentration of forces at a point of threatened invasion of disease, the avoidance of widespread apprehension and panic, which a national administration would favor, the full and direct consular assistance and the promise of international co-operation, the equable distribution of the expenses of a protective agency in whose benefits all parts of the nation share, and the removal of disastrous conflicts and pecuniary ambitions often openly pursued, regardless of public weal. The bill did not pass, but many of its provisions were incorporated in the act of 1893. The Convention of Southern Congressmen, representing 14 Southern States, held in Chattanooga, Tenn., in 1905, resolved that the many antiquated methods of quarantine hitherto resorted to were futile and onerous, and that in the interests of public health and public business, uniform regulations must be adopted, and accordingly resolved to request Congress to enact a law whereby the coast maritime and national frontier quarantine should be placed exclusively under the control and jurisdiction of the United States Government.

In the meantime, although there were no acts passed which gave the Federal Government direct power over the quarantine at all parts of the country, the trend of all the legislation in this connection was toward this goal. A number of national quarantine acts were passed from 1799 to 1893; the first required federal officers to aid the local agencies in the execution of State or municipal quarantine regulations; later (1883) one for maintaining quarantine points along the coasts, known as "refugee stations," and in 1906, $600,000 was voted by Congress for the organization of the quarantine in the South.

From time to time, also, acts were passed increasing the powers and broadening the sphere of work of the Federal public health service. The acts of 1890 and 1899 charged the surgeon general of the Marine Hospital Service with the preparation of the rules and regulations necessary for preventing the introduction of certain contagious diseases from one State into another, and also the supervision over the medical inspection of alien immigrants. All these acts, however, provided that the measures were for the purpose of aiding the State and local quarantine authorities, and did not give the Federal Government the power of supervision over them. *This was first done* in the Act of 1893, which gave the Secretary of the Treasury, through the Marine Hospital Service, the power to promulgate uniform quarantine regulations for all the ports of the United States, which rules must be enforced by the State and municipal authorities, if they choose to undertake to enforce them; and in case of their refusal or failure to carry out these regulations, the President is empowered to detail federal officers for that purpose. This act also gave the Marine

Hospital Service the power to examine the quarantine stations of a State or municipality and their regulations. Also where a State or municipality shall transfer to the United States their quarantine stations, they shall reasonably be reimbursed for the same.

Like modern commerce, modern maritime quarantine is not a matter of local character and importance, but is esentially national or even international in its significance and its bearing on the health of the people. For instance, the Baltimore Quarantine Station is not local in character. It protects the people of the whole country. It quarantines for Chicago or Pittsburgh or Minnesota as much as for Baltimore city or Washington or the State of Maryland. A highly contagious disease brought into one city or State will spread like a conflagration to other cities and States or countries without any regard to imaginary State lines. When Baltimore quarantines vessels and passengers infected with malaria or yellow fever, it is not protecting the citizens of Baltimore or Maryland as much, or any more, than those of the South. The same would also be true of plague or Asiatic cholera.

The greatness of Baltimore's shipping, and its importance as an immigration center, ranking fourth in the country in this respect, with bright prospects of great growth in the tide of immigration when the new immigration station, recently provided for by an act of Congress, is completed, makes Baltimore pre-eminently national in character.

Here we have one of the large quarantine stations of the country. Forty thousand to 50,000 persons, and $28,000,000 worth of goods come into this port in one year, with exports to the value of $100,000,000. The financial burden of administration of Baltimore's quarantine, which serves the whole country, rests on Baltimore city—the taxpayers of the city. In the neighborhood of $28,000 annually are required to meet this outlay. Of this amount foreign shipping contributes from $14,000 to $15,000 in the way of quarantine fees, leaving a yearly deficit of from $13,000 to $14,000, to be made up by appropriations by the city.

Under a locally administered quarantine the brunt of the expense of keeping diseases out of the country at large is borne not by the whole nation, but by the individual city. If this station was under Federal control, not one cent would be collected from shipping for quarantine purposes, and Baltimore would contribute *only* its pro rata, along with all other cities of the United States. This is a great benefit to shipping, as will readily be seen, and by the removal of all quarantine fees not only is the shipping relieved, by the proposed change of ownership and administration, but the taxpayers of Baltimore city would be relieved of the large and unnecessary annual outlay. Quarantine fees would be abolished in toto, and shipping would be benefited accordingly, and the amount now contributed for this purpose by shipping interests would find its way instead into the pockets of the stockholders in the way of increased dividends.

The record of the work of local quarantines has shown repeat-

edly that they are unable, without help from outside, to keep out the various quarantinable diseases brought in from foreign countries. This has been admitted in many instances by the States and cities, and many State and city stations have been given over voluntarily to the national Government. In many instances the national Government was asked for assistance, and in many other cases it had to give assistance on its own initiative.

The great city and State of New York were unable to cope with the cholera situation of 1892 and 1911; Federal officers had to be sent to assist the State officers. The history of yellow fever in New Orleans and other Southern cities, and of plague in San Francisco, is but a repetition of New York's experience. In times of such crises the people do not look to the local authorities for relief, but to the national Government.

All the quarantine conferences, national and international, have strongly recommended uniformity of quarantine rules as a matter greatly desired for the safeguarding of health, as well as a convenience to commerce. It is a great convenience to the maritime interests to know that the requirements of one port apply in the same way and measure to all other ports. All the most important nations of the world have adopted a uniform system of quarantine rules and regulations in the international sanitary agreement heretofore spoken of, in order to facilitate commercial intercourse and make discriminations against countries and individual vessels impossible. Prior to 1893 there was no national system of quarantine in the United States. Since that time 47 ports out of a total of 50 ports of entry in the United States where quarantine is maintained have come under Federal authority, showing how *rapidly* this transfer is being made; and all who have thus come over would not go back to the old way, for they have found Federal control more effective in safeguarding the people from contagious diseases, and of more assistance to commerce rather than a detriment, as some believed before they had tried it.

In order that the United States may be a responsible party to international agreements, it must have control and supervision of all the ports of the country. As showing the tendency in this direction, Philadelphia, or rather Pennsylvania, but recently transferred her quarantine to the Public Health Service, as also did Providence, R. I., while Virginia discontinued her quarantine stations at both Newport News and Norfolk, which are now both administered by the Government quarantine at Old Point Comfort, Va. This station also controls Baltimore's shipping, and can be put in use at any time for this city, as was done in former times in periods of threatened invasion of contagious diseases from foreign countries. The New York quarantine is now seriously considering coming under Government control, and also Boston.

The Federal Government controls all the services incident to the administration of the port of Baltimore, with the single ex-

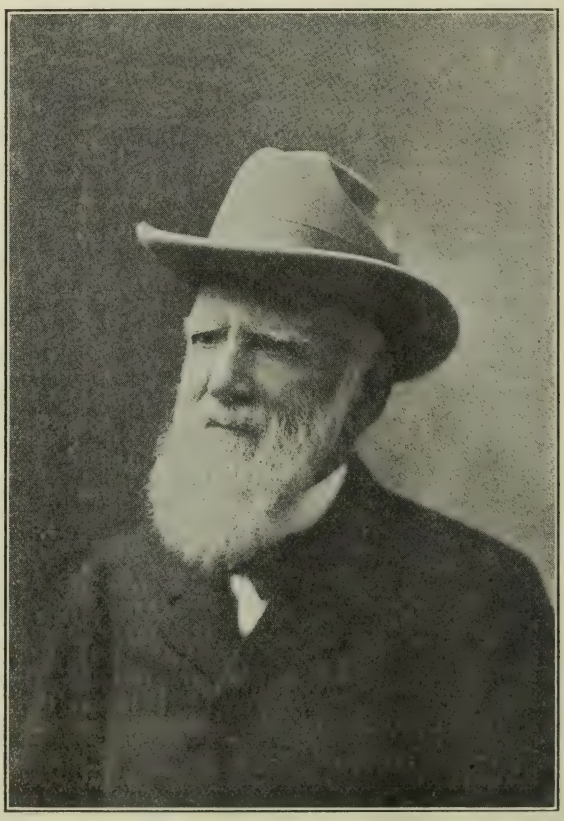
ception of quarantine. In addition to the customs and immigration administration, the Government maintains the Revenue Cutter Service, which protects life and property, has control over the hydrography of the port, the navigable channels and dredging, over lighthouses, and exercises care over sick and disabled seamen. It seems but logical and consistent to extend its power to the quarantine, and concentrate the whole administration of the port in the hands of the Federal Government.

The Treasury Department, by correlating its customs division and revenue-cutter division with the quarantine service, is able to furnish the latter with a great amount of assistance; and convenience, economy, efficiency and expediency could also be obtained if the quarantine inspection and the medical examination of immigrants at Baltimore could be conducted by the same set of officers at once instead of by two sets, one State and the other Federal, as is the case at present. The co-operation of other departments of the Government can also be readily obtained in times of grave crises.

The Public Health Service, through the courtesy of the Department of State and its Consular Bureau, is in direct and constant touch with all parts of the world. While the State and municipal quarantine officers receive the weekly bulletins of the bureau, they have no such intimate and direct knowledge of health conditions abroad as have the officers of the Public Health Service. To obtain this they are frequently obliged to send their own officers abroad.

The last and perhaps one of the most important reasons for the national control of quarantine is the absolutely imperative need that the office of health officer of a port be taken out of politics. It is universally recognized that scientific work of any kind can be done efficiently *only* under the condition of permanency of office. The work of quarantine officers is *essentially* scientific, and the incumbents of these offices should be secure in their positions during good behavior and efficiency. Under State or city control, as the remaining three quarantines not already under Governmental control are at present, changes of personnel may, and often do, occur with each change of administration. Under the Federal control there is continuity of service, uniformity of procedure and policy, constant supervision over the acts of the quarantine officers, and abundant opportunities for scientific and administrative training in the various ports of the country, such as is not available to the officer of any State or municipal quarantine station.

Finally, if I may be permitted to express a personal opinion, I cannot understand why all the quarantine stations in the United States, with everything in their favor by transferring, and a great deal against them should they not transfer, have not already come under governmental control. It is a function which the 19 other leading powers of the world, signatory to the international sanitary agreement, long since delegated to the national governments.



A. V. CHERBONNIER, M.D.

# THE MEDICAL FATHERS OF BALTIMORE COUNTY, MARYLAND.*

A BIOGRAPHICAL SKETCH OF

## DR. A. V. CHERBONNIER, U. S. A. (Retired).†

*By Dr. William J. Todd,*
Mt. Washington, Md.

Dr. A. V. Cherbonnier located, in the year 1855, in what was then known as Washingtonville, now Mount Washington. His office was in a small two-story house on the Falls road turnpike, once used as a store by Victor Sirata, from whom he rented it, and immediately opposite the old stone store and meeting-house.

He read medicine with Professor Dunbar, and was a graduate of the University of Maryland in the class of 1848. After a year in walking the wards of the hospitals in New York city, he returned to Maryland, and settled on the Belair road, renting a stone house from the late Nicholas Gatch, from whom he received his first fee ($60) and the use of the house and lot for one year free of rent.

He removed from the Belair road to Washingtonville, remaining a few years. He purchased a stone cottage and three acres of land from the late Isaac Mankin, who owned nearly all of the land around what was then known as "Slabtown," now Hampden, Baltimore city. He remained there until 1862, when he accepted a position as acting assistant surgeon in the United States Army.

He was in the battles of South Mountain and Antietam. After the battle of Antietam he was ordered to report to Surgeon H. S. Hewitt, U. S. V., in charge of the Convent and Novitiate Hospital, Frederick, Md. He served under Surgeon Hewitt, remaining until the last hospital was closed, and assisted Surgeon Hewitt on his numerous reports.

He was ordered to Camp A, two or three miles from Frederick, and served under Surgeon W. H. Notson. From Camp A he was ordered to the Naval Academy Hospital, Annapolis, Md., serving under Surgeon Von der Kief, U. S. V., in charge. Surgeon Von der Kief placed him in charge of the officers' hospital, which was a hospital inside of a hospital. After serving over a year there he was ordered by Medical Director Simpson to report to Surgeon Sims, U. S. V., in charge of Patterson Park Hospital. During his term of service at Patterson Park Hospital he was the executive officer. He did not, however, remain very long, having made a damaging report to the surgeon in charge as to the quality of the meat furnished the soldiers. This hospital was situated on the

*Read before the Baltimore County Medical Association, July 16, 1913.

†Dr. Cherbonnier was present at the meeting and was made an honorary member of the Baltimore County Medical Association.

site of what is now known as Patterson Park. It was composed of a few buildings and many tents.

From Patterson Park he went to Camp Parole, serving three months under Surgeon Pettinas, U. S. V. From there, Surgeon Von der Kief, having made a request that Dr. Cherbonnier should again be assigned to him, he returned to Annapolis. Dr. Cherbonnier remained with Surgeon Von der Kief until after the assassination of President Lincoln, when he was ordered to report to Surgeon Cooper McKee, U. S. A., in charge of the Lincoln Hospital, Washington, D. C., where he served until the close of the war.

Thinking that his services would no longer be required, he requested that his contract be annulled, which was done; a few days later he received a letter from Surgeon General Barnes, offering him a position under Surgeon Basil Norris, U. S. A., who was attending surgeon United States Army, Washington, D. C., increasing his pay $25 a month, giving him commutation of quarters, a horse and buggy and an orderly. He was assistant to Surgeon Norris for three years, and attending surgeon, at the end of which time he was given a commission in the Medical Corps of the Army, with the rank of captain, which commission he still holds.

In 1866 he was ordered to St. Louis, Mo., taking charge of the medical purveying depot, which post he held for over three years. From St. Louis he was ordered to Santa Fe, New Mexico, closing up the purveying depot at that place. At the end of the year he was ordered to the office of the Surgeon General of the Army, and after finishing the work he was required to do he was given a leave of absence without solicitation. At the end of his leave he was ordered to San Antonio, Texas, to establish a medical purveying supply depot, which he did. The building of railroads rendered the purveying depot at San Antonio unnecessary. In three years it was closed, and Captain Cherbonnier was ordered to New York, where he remained nearly four years, at the end of which time he was ordered back to St. Louis, where he remained until retired from active service, which, after a most active and eventful life, took place "for age" October 12, 1890.

The father of Dr. Cherbonnier was Pierre Cherbonnier; born at Saintes, on the Charente River, France, March 21, 1781. He was a medical officer in the French Navy, and came to this country with Victor Emmanuel LeClerc (who married one of Napoleon's sisters) in 1803. Dr. Pierre Cherbonnier was not a Bonapartist. He sent in his resignation and came to New York. From there he went to New Orleans, La., where he settled and later married. He came to Belair, Harford County, Md., with his family in 1830, where he died April 5, 1866.

Dr. A. V. Cherbonnier was born October 12, 1826, in New Orleans, La. He received his early education in Belair, Harford County, Md.; later under the private instruction of Prof. John

Neely of Baltimore, and still later at St. Mary's College, Baltimore, Md.

The subject of our sketch had an older brother—Pierre Ovid Cherbonnier—also a physician, who graduated from the University of Paris in 1840. After graduating he returned to the United States, settling in Baltimore city, and later in Easton, Talbot County, Md., where he attained great success and prominence in his life's work. Dr. Cherbonnier had two sisters. The eldest became the wife of the late James L. Bartol, for 25 years Chief Justice of Maryland. The other sister became the wife of E. R. Sprague, a prominent attorney of Baltimore.

Dr. Cherbonnier was married three times. His first wife was a Miss Goodwin, with whom he had four children. Three are living. The second wife was a Miss Sarah C. Cairns, daughter of the late James Cairns, with whom he had one child, a daughter, who married Dr. Eugene F. Raphel of Upper Falls, Baltimore County, but now of Wheeling, W. Va. His present wife was Miss Rose Coyne, with whom he has a son, named after him, now 12 years of age.

Dr. Cherbonnier is a genial, social gentleman, fond of company and all kinds of sport. He is noted for his skill at cards, and for being one of the best chess players in Maryland when at his best. He is now living in Baltimore, Md., and is leading a quiet and peaceful life, and though in his eighty-sixth year, he is well preserved, and enjoys excellent health. His handwriting is plain and distinct, and impresses one that the lines were written by a much younger man. He still plays chess, but because of his impaired eyesight, he no longer claims to be an expert player.

Two cataracts which affected his vision have been removed. His summers are spent in the mountains of West Virginia, where he has become well known, and is very popular with card players

In answer to my request regarding Dr. Cherbonnier's recollection of the physicians of his early professional days, he answered: "The leading physicians of my earlier days were, notably, the late Nathan R. Smith, who had no superior in this country, though very little known in Europe. My brother, Dr. P. O. Cherbonnier, who lived in France over 10 years, studied medicine and graduated at the University of Paris, informed me that he had never heard of Dr. Smith, but when he returned from France to the United States, and saw Dr. Smith perform surgical operations, he stated that Dr. Smith had no superior in the world, and very few equals, in his opinion. At the head of the list we had Drs. John and Thomas Buckler, Surgeon Baxter, Dr. Gibson, Dr. Dunbar, Dr. MacKenzie, Dr. Roby, demonstrator of anatomy University of Maryland; Dr. Gittings of Baltimore County, Dr. Powers of the University of Maryland; also Dr. Potter and Dr. Thomas. These were the leading physicians of Baltimore city, although there were many others quite distinguished. I cannot

compare them with the physicians of today. Such a revolution has taken place in the treatment of disease, no doubt great advancement has been made, but as to the practice of surgery, I think, if Dr. Smith were living today, he would still retain the title of 'The Emperor.'

"With the exception of cases reported by me during the Civil War, and published by the Surgeon General of the Army, in a work printed by the Government, I have written nothing."

Dr. Cherbonnier recalls Dr. Septimus Dorsey, who practiced in Mount Washington, and at one time had an office on the Falls road in a stone house which was afterwards removed to make room for the building of a brick house owned by the late William Welsh.

Dr. Cherbonnier was succeeded by Dr. Donahue, who came to Mount Washington in 1856, and died there in 1859.

Dr. Cherbonnier was well acquainted with Dr. Thomas Buchanan Steele, who lived in Mount Washington in 1865, remaining there about two years. Dr. Steele was the father of Dr. Guy Steele of Cambridge, Md., who, like the subject of our sketch, made a record for himself during the Civil War, acting as surgeon in the United States Navy. In 1901 I read a sketch I had written of the life of Dr. Steele to Dr. Cherbonnier, who ended his hearty indorsement with "I never knew a handsomer man."

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VACCINE AND SERUM THERAPY. Including also a Study of Infections, Theories of Immunity, Specific Diagnosis and Chemotherapy. By Edwin Henry Schorer, B.S., M.D., Dr.P.H., formerly Assistant Thomas Wilson Sanitarium for Children, Mt. Wilson, Md.; Assistant Rockefeller Institute for Medical Research, New York city, and at one time member of the Faculty of the University of Missouri, of the University of Kansas and the Department of Preventive Medicine and Hygiene of Harvard University. Second revised edition. St. Louis: C. V. Mosby Company. 1913. Cloth, $3 net.

Vaccine therapy has come into such universal use in the treatment and prevention of disease, and has made such rapid strides during the past few years, that a dependable guide in the administration of the several serums is indeed a welcome addition to our literature. Since the last appearance of this book new studies and observations have materially extended the scope of the use of vaccines, so that now practically all infectious diseases are treated in this manner. It is for the purpose of incorporating these additions to our knowledge that the book has been rewritten, and in its new vestments will be found more serviceable than ever. That it has met a need is attested by the promptness with which the first was exhausted and the urgent calls for a new edition. We predict for this edition even greater popularity than that enjoyed by its predecessor.

# MARYLAND MEDICAL JOURNAL

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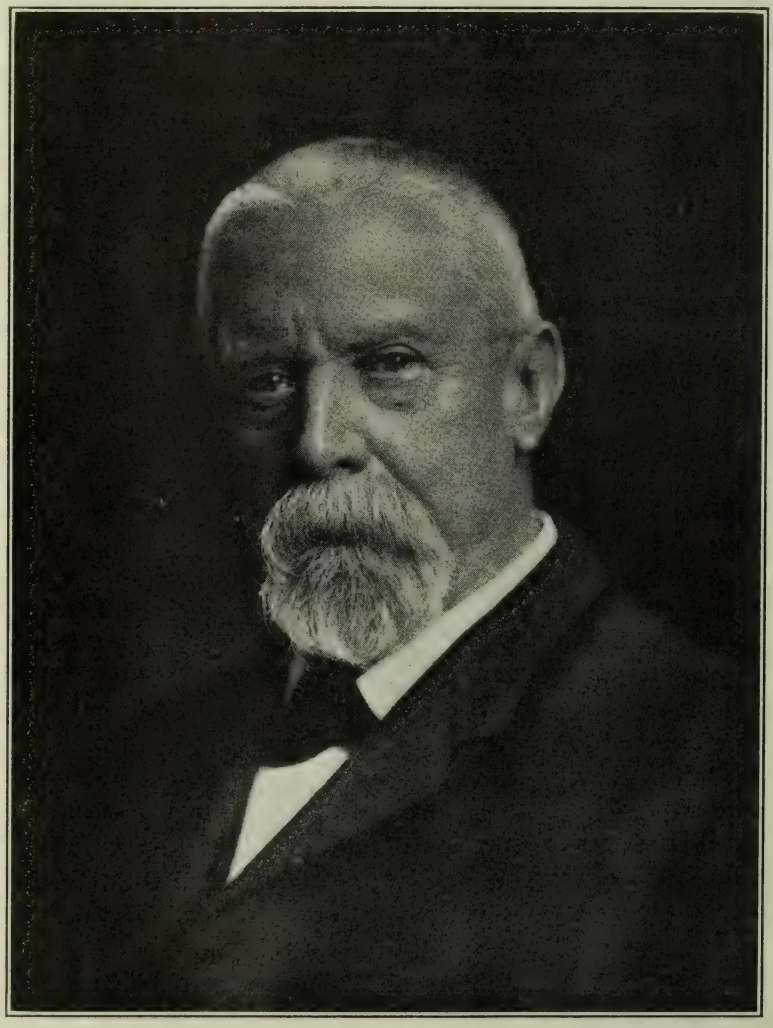
BALTIMORE, NOVEMBER, 1913


## DR. NATHANIEL GARLAND KEIRLE.

THE old saying that a prophet is not without honor save in his own country is generally an axiomatic truth. Occasionally, but only too infrequently, associates do recognize merit. This is true in the case of Dr. Nathaniel Garland Keirle, A.B., A.M., M.D., D.Sc., a native Baltimorean, who is recognized by laity and profession alike as one of the foremost living authorities on hydrophobia.

Dr. Nathaniel Garland Keirle was born in the city of Baltimore, October 10, 1833, and is the son of the late Matthew M. Keirle of Baltimore, and of Sarah Jacobs Garland of Danvers, Mass. On both sides of his family he is descended from distinguished colonial stock. As both of his parents died before he was seven, he was reared by his paternal grandmother. His early education was obtained at private schools, St. Mary's Seminary, Public School No. 6 and the Baltimore City College. He then entered Dickinson College, passing through both the preparatory school and collegiate department, and, in 1855, rating number two in his class, he was granted the degree of Bachelor of Arts by that college.

After the completion of his college course he returned to Baltimore, determined to enter upon the reading of law, but was discouraged by a prominent lawyer on account of his age—22 years. He then turned to medicine, and entered the medical department of the University of Maryland, from which he was graduated with the class of 1858, Drs. Samuel C. Chew and Edward F. Milholland, both of Baltimore, being classmates. While attending lectures at the university he was an office student of the late Dr. George W. Miltenberger, class of 1840, and for years professor of obstetrics in the University of Maryland. In conformity with usage, the regents of the University of Maryland, desiring to place upon their honor roll the names of certain distinguished men, caused a mandate to be issued, directing that at their centennial celebration (1907), as a personal token of admiration of his investigations in science, especially in studies and investiga-



NATHANIEL GARLAND KEIRLE, A.M., M.D., D.Sc.

tions in hydrophobia, the degree of Doctor of Science be conferred upon Dr. Keirle. On presenting Dr. Keirle, Prof. Randolph Winslow said: "I have the honor to present one whom the regents have deemed worthy of special distinction, and whose name is mentioned in their mandate—Dr. Nathaniel Garland Keirle of Baltimore—and request that the honorary degree of Doctor of Science be conferred upon him.

"Dr. Keirle graduated from the medical department of this university in 1858, and has passed his life in this city in the pursuit of his profession. He has held a professorial chair in the College of Physicians and Surgeons for many years, but it is as the director of the Pasteur Institute of this city that he has attained his greatest usefulness and achieved his highest reputation. By his successful treatment of those bitten by rabid animals he has proved himself a veritable bulwark of this and neighboring communities against that dread disease, rabies, and I therefore take great pleasure in presenting him for the degree of Doctor of Science."

This was no barren honor, but an honor won by hard, faithful and conscientious researches in the investigation and treatment of those liable to develop rabies.

On October 10, 1913, Dr. Keirle, chief of the Pasteur Institute of Baltimore and city post-mortem physician, celebrated his eightieth birthday as the guest of honor at the University Club at a dinner tendered by his colleagues at the College of Physicians and Surgeons as an expression of appreciation of his worth. It is the privilege of but few men in any walk of life to be permitted to serve mankind over such an extended period as Dr. Keirle. With mental faculties undimmed by the ravages of time, and with a sound body, Dr. Keirle still exhibits those qualities which enabled him to reach the top rung of professional success. Owing to his great dislike for publicity, Dr. Keirle's great service, not only to the profession, but also the community at large, has not been fully appreciated. Adulation is distasteful to this simple-living American scientist. His satisfaction comes from a full realization of a work well done; no other approval does he desire. Nevertheless, the profession of Maryland has and does take a personal interest in the continued health, happiness and prosperity of this grand old man, and through the pages of the Maryland Medical Journal extends to him its cordial best wishes for many years more of beneficent service to those bitten by rabid animals, and felicitates him upon the completion of 55 years of service devoted to the alleviation of pain, distress and sickness.

## Medical Items.

Captain Wm. C. Davis, M.C., U. S. A., Baltimore University School of Medicine, '96, of Summerfield, N. C., was relieved from duty in the Philippine Department, to take effect after August 15, 1913, and ordered to proceed to the United States and await further orders from the Adjutant General of the Army.

The Franklin Institute, Philadelphia, has conferred on Harry C. Jones, professor of physical chemistry in Johns Hopkins University, the Edward Longstreet medal of merit for his article entitled, "The Nature of Solution."

Dr. and Mrs. J. Albert Chatard, of 40 West Biddle street, have closed their residence and gone to Maine, where they will spend the remainder of the summer.

In his annual report, issued recently, Dr. Winford H. Smith, superintendent of the hospital, made an urgent appeal for an increased endowment for the Johns Hopkins Hospital.

The Maryland Medical College, Dr. W. S. Smith, dean, which was founded about 15 years ago, was ordered closed September 8, 1913, for the season, following a meeting of the board of trustees. The 100 students enrolled at the college will continue their studies at various institutions throughout the country. It is thought that the college will either reorganize, to start a year later, or will merge with some other institution.

The physicians and surgeons of Johns Hopkins Hospital were guests of the Catonsville Country Club Saturday, September 13, 1913. In the afternoon there was a baseball contest, followed by a dinner and dance.

Dr. Louise Pearce, the only woman on the staff of Johns Hopkins Hospital, has been appointed an assistant to Dr. Simon Flexner, of the Rockefeller Institute, New York, to take effect October 1, 1913. Her appointment is unique in American medical annals, as she is the only woman ever named to work directly with Dr. Flexner.

The health authorities of Baltimore City are using 3000 pounds of hypochlorite of lime daily, with a view of purifying the drinking water of the city and limiting the prevalence of typhoid fever. A report shows that 90 per cent. of the bacteria in the water last year were killed by the use of hypochlorite of lime.

Dr. Arthur Louis Fesenfeld, University of Maryland, '01, has been appointed medical examiner of schools, vice Dr. I. F. Page.

The Allegany County Tuberculosis Sanatorium of Haystack Mountain, near Cumberland, has been completed, and was thrown open to the public September 4, 1913. It will accommodate about 20 patients.

Dr. C. L. Andrews, of Johns Hopkins University, has accepted the position of professor of anatomy in the University of Mississippi Medical College.

Dr. Joseph C. Bloodgood, who has been spending the month of September with his family at Cape May, N. J., has returned to his home in Baltimore.

The International Medical Congress, the most successful in the history of medicine, was opened by Prince Arthur of Connaught, representing King George, in the great Albert Hall, London, August 6, 1913, in the presence of an audience of 10,000. American doctors took a prominent part in the congress. Prof. Harvey Cushing, of Harvard University, formerly of Baltimore, delivered an address on "Surgery." Dr. William H. Welch, of Baltimore, also delivered an address. Sir William Osler gave a big dinner to delegates to the congress at the Automobile Club. Many of his old friends at Johns Hopkins, including Dr. William H. Welch and Prof. W. S. Thayer, were present. The representatives of the United States easily outnumbered those of any other nation except England. The congress adjourned August 12, 1913.

Among those who attended the Fourth International Congress on School Hygiene, held in Buffalo, N. Y., the last week in August, were Drs. Leonard K. Hirshberg, Donald R. Hooker and James M. Delevett.

Extensive improvements are being made by Dr. Lewis H. Gundry to the Relay Sanitarium, including a large addition to the present building.

Dr. A. Samuels, of 1928 Eutaw Place, sailed August 2 from New York for Europe on the White Star steamer Olympic to attend the International Medical Congress.

Dr. Frederick H. Baetjer of the Johns Hopkins Hospital, who lost four fingers of his right hand a year ago from X-ray burns, is recovering from an operation of grafting the skin of his abdomen on the hand. Dr. Baetjer is one of

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the foremost X-ray specialists in the city. He began using the X-ray in the days when little was known about the machine and the effects of the ray upon the body, and, like almost every physician who employed the instrument in the early days, suffered severely. After he had been an X-ray operator nearly 16 years, Dr. Baetjer's four fingers on the right hand had to be amputated on account of infections. We are glad to learn that the operation has been a success and that Dr. Baetjer has sufficiently recovered to be able to leave the hospital and return to his home.

J. H. Branham, M.D., College of Physicians and Surgeons, '79, of 2200 Eutaw place, and George W. Dobbin, M.D., University of Maryland, '94, of 56 West Biddle street, were the speakers at the meeting of the Baltimore County Medical Association October 15, 1913, at Middle River, Md.

George Canby Robinson, M.D., Johns Hopkins Medical School, '03, of New York city, who has been connected with the Rockefeller Institute, will shortly move to St. Louis, Mo., which he will make his future home.

Max Einhorn, M.D., of New York city, a stomach specialist, and A. Lohenolt, M. D., of Halle, Germany, who is here to make a study of the Baltimore hospitals, are registered at the Belvedere Hotel. They will visit many of the hospitals here.

Edward G. Altvater, M.D., of 321 North Carrollton avenue, has succeeded Dr. Albert D. Driscoll as assistant physician at Quarantine. Dr. Altvater makes the third assistant at the station within the last two years.

Dr. Thomas P. Sprunt, Johns Hopkins Medical School, '09, has been appointed professor of pathology in the Graduate School of Medicine of the University of Alabama, Mobile.

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### BIRTHS.

Recently, to Howard J. Maldeis, M.D., Maryland University Medical School, '03, and Mrs. Maldeis, of Kate avenue and Reisterstown road, Baltimore, Md., a son.

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### MARRIAGES.

William D. Hammond, M.D., University of Maryland, '08, of Hagerstown, Md., to Miss Camille Bringhurst of University City, St. Louis, at Alton, Ill., September 16, 1913. After a short wedding trip Dr. and Mrs. Hammond will reside in Hagerstown.

Peter Prentiss Causey, M.D., University of Maryland, '97, of Wilmington, N. C., to Miss Esther Elizabeth Brewington, University Hospital Training School for Nurses, class of '07, of Baltimore, Md., at Baltimore, September 17, 1913.

Merle D'Aubigne McCutcheon, M.D., College of Physicians and Surgeons, '08, of East Liverpool, Ohio, to Miss Louise Alberta Sturtevant of Walbrook, Md., at Westminster, Md., October 1, 1913.

John William Robertson, M.D., University of Maryland, '09, to Miss Lulu Conway Price, University Hospital Training School for Nurses, '10, both of Onancock, Va., at Onancock, October 2, 1913.

Thomas Joseph O'Donnell, M.D., University of Maryland, '03, of Baltimore, Md., to Miss Anna May Brophy of Frostburg, Md., at Frostburg, October 9, 1913. After an extended Southern trip Dr. and Mrs. O'Donnell will live at 107 East West street, Baltimore.

Fitz Randolph Winslow, M.D., University of Maryland, '06, of Baraboo, Wis., to Miss Florence I. Reese of Baltimore, Md., at Baraboo, October 1, 1913. Dr. Winslow is a son of Prof. Randolph Winslow and was formerly resident surgeon in the Maryland University Hospital. He recently moved to Baraboo, where he is engaged in the practice of surgery.

Michael J. McDermott, M.D., University of Maryland, '10, of Waterbury, Conn., to Miss Edna M. Cowan of Baltimore, Md., at Baltimore, October 15, 1913. They will reside in Midling, Md.

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### DEATHS.

Garland Payne Moore, M.D., College of Physicians and Surgeons, '86; acting Assistant Surgeon, U. S. P. H. S.; a member of the Medical Society of Virginia, whose last station was at Kobe, Japan, where he was on duty at the American Consulate, died suddenly at sea September 9, 1913, while en route to the United States, aged 49 years.

Joshua Webster Hering, M.D., University of Maryland, '55, of Westminster, Md., died at his home in Westminster September 23, 1913, after a lingering illness, aged 80 years. Dr. Hering was a former Public Service Commissioner, State Comptroller and prominent Democrat.

MARYLAND
MEDICAL JOURNAL
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LVI, No. 12 BALTIMORE, DECEMBER, 1913 Whole No. 1147

# A CASE OF BI-LATERAL EMBOLISM OF THE CENTRAL ARTERY OF THE RETINA, WITH THE PRESERVATION OF CENTRAL VISION OF THE RIGHT EYE.

*By E. A. Knorr, M.D.,*
Surgeon, Presbyterian Eye, Ear, Nose and Throat Hospital, Baltimore, Md.

THE clinical symptoms, ophthalmoscopical picture and pathology, caused by the sudden interruption of the circulation of the central artery of the retina, are exceptionally characteristic and in their details always the same. The disease was described by Albrecht von Graefe (*Arch. fur Ophthalmol.*, 1859,) and since then has passed under the clinical term of embolism of the central artery of the retina, although perhaps the majority of the cases are due to thrombi or an obliterating endarteritis.

The annual reports of the Presbyterian Eye, Ear and Throat Charity Hospital of the past seven years show nine cases of embolism of the central artery out of a total number of 44,318 eye cases, thus 1 to 4927.

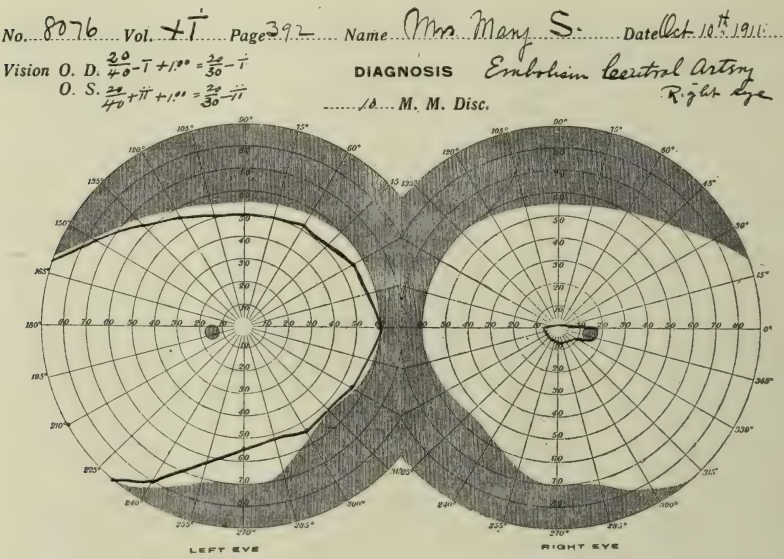
The following is the history of a case of the above mentioned disease, which is unusual in that the eye first affected retained a small central visual field, and, secondly, two years later, embolism of the central artery of the retina occurred upon the opposite side, causing complete blindness of this eye.

MRS. M. S. WHITE, AGE 48 YEARS.

*Family History*—Father living and well at the age of 78 years; mother died at the age of 65 years and at that time was deeply jaundiced. Had three brothers; one died at the age of 22 years of accident. Had three sisters; one died at the age of 30 years of cancer of the breast; one died at the age of 52 years and was deeply jaundiced at time of death.

*Past History*—Married at the age of 22 years; had 10 children, seven of whom are still living and well; one died at the age of

two months; one died at the age of seven years of diphtheria; one died at the age of 12 years of rheumatism and heart disease. Confinements were all normal; patient has always been well until September 28, 1911; while engaged in washing clothes noticed that the vision of the right eye suddenly became blurred and that she retained a small central field of vision. Ophthalmoscopic examination the following day revealed the picture of embolism of the central artery of the retina. Right pupil larger than left and reacts slowly to light; retina opaque and cloudy, obscuring the retinal vessels in places; disc obscure; margins not discernible; cherry spot at the macula; no retinal hemorrhages; vision; hand movement at six feet; this condition gradually subsided and was followed by optic atrophy, but patient retained central vision, which


No. 8076 Vol. +T Page 392 Name Mrs. Mary S. Date Oct. 10th 1911
Vision O. D. 20/40 -T +1.00 = 20/30 -T
O. S. 20/40 +II +1.00 = 20/30 -II
DIAGNOSIS Embolism Central Artery Right Eye
Id. M. M. Disc.
LEFT EYE
RIGHT EYE

gradually improved and is now 20/20 + iv with correction. The vessel that maintains the integrity of the macula cannot be made out by ophthlamoscopic examination, as it is not one of the typical hook-shaped vessels that emerge at the margin of the disc.

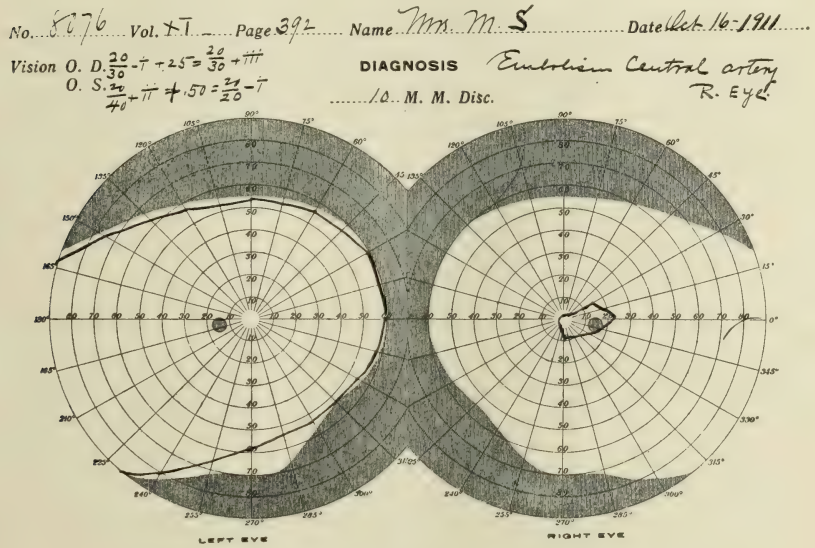
February, 1912, patient suffered a right-sided stroke of paralysis from which she has not entirely recovered.

May 12, 1913, while engaged in hanging up clothes patient noticed that the vision of the left eye became dim; objects appeared silvery, then gray and finally were blotted out. Examination the following day showed the following condition: Pupil semi-dilated, loss of pupillary reflex to the direct stimulation of light but retention of the consensual reaction, refractive media clear; fundus shows white clouding of the retina which is most marked adjoining the disc, obscuring the latter. The disc projects a little forward. The retina vessels are obscured in places near the disc

where they dip into the cloudy retina. The macula is occupied by a dense red cherry spot, which is surrounded by a dense white area. Fine macular vessels can be seen approaching the macula from above and below, but are a little obscured; as we proceed from the macula and disc toward the periphery of the fundus the retina gradually becomes more transparent and of a cloudy pink hue. There is no light in this eye.

While the frequency of embolism of the central artery is about 1 to 4500, the number of cases which have been examined histologically while still presenting the early changes, such as the cherry spot and retinal clouding, are comparatively rare.

Dr. J. Rubert (*Klin. Monatsbl. für Augenheilk.*, 1911,) has found 23 cases reported in the literature up to 1905; but few of


No. 876 Vol. XI Page 392 Name Mrs. M. S Date Oct. 16-1911
Vision O. D. 20/30 -1 +.25 = 20/30 +II
O. S. 20/40 +II +.50 = 20/20 -1
DIAGNOSIS Embolism Central artery R. Eye
O. M. M. Disc.
LEFT EYE
RIGHT EYE

these cases were entirely satisfactory, owing either to postmortem changes before enucleation, or that the acute stage had subsided before death, from insufficient description, etc. One of the most satisfactory and complete reports is from the Kiew University Eye Clinic, 1900, which is reported as follows:

July 20, 1900—Gastrostomy performed upon a 41-year-old man.

August 30, 1900—Patient noticed that he suddenly lost the sight of the left eye. He was ophthalmoscoped the following day and showed the typical picture of embolism of the central artery of the retina.

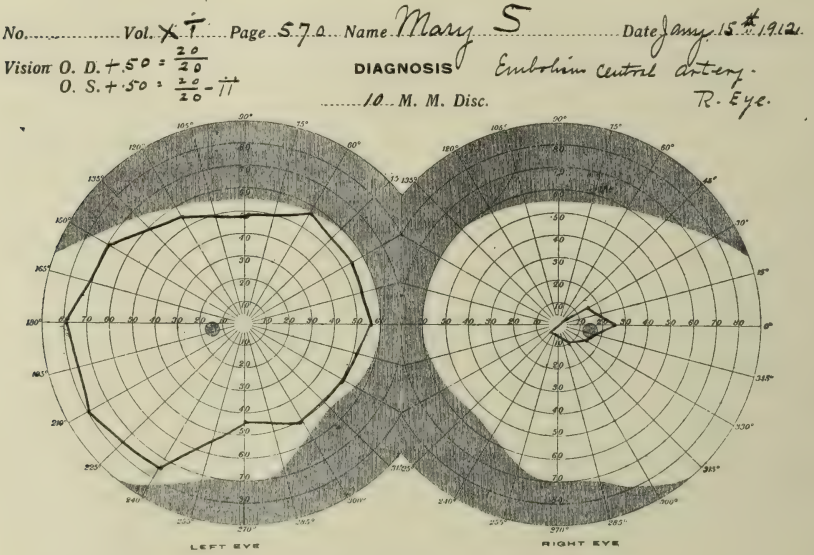
September 3, 1900—Patient died; eye enucleated shortly after death; thus, four days after onset of blindness. Miscroscopical examination as follows:

The papilla is markedly swollen and projects into the interior of the eye and is slightly detached from the retina; more marked

on the nasal side; this increase of volume is due to edema. The nerve fibres are separated, swollen, pursue a wavy course and, in places, necrotic.

They enclose numerous vacuoles of varying size; there are numerous granular, fat cells, which stain rose red with eosin, some contain remains of nuclei which do not stain with nuclear dyes; here and there are met homogeneous, bullet-shaped elements, which stain blue with haemotoxylin, amyloid reaction and obtained, nuclei of glia cells not materially changed, but occasionally vacuolation and pyknosis. The fixed cells are not increased and wandering cells cannot be seen.

The changes in the nerve fibre layers are similar to those of the papilla, only less pronounced; the changes at the papilla are most


No. Vol. X 1 Page 570 Name Mary S Date Jany 15th 1912.
Vision O. D. +.50 = 20/20
O. S. +.50 = 20/20 - 11
DIAGNOSIS Embolism central artery.
10 M. M. Disc. R. Eye.
LEFT EYE
RIGHT EYE

pronounced, gradually become less intense toward the periphery, but are well pronounced four to six papilla diameters from the disc. The edema extends to the adjoining layers, excepting only the rods and cones and the outer molecular layer.

The ganglion cell layer contains numerous vacuoles, which crowd the cells together; some cells show vacuolation of the nuclei and cell protoplasm, and many have lost their chomatin substance entirely or possess but slight remains; others are shrunken and the nuclei stain deep blue with haemotoxylin, in places the pyknotic nuclei are degenerated, these changes are most pronounced at the papilla, beyond two papilla diameters the cells are well preserved.

The inner molecular layer is edematous, but not markedly so.

The inner nuclear layer is vacuolated, the vacuoles crowd the cells together, many nuclei are shrunken and stain intensely blue

with haemotoxylin; some are swollen, stain faintly and contain chromatin remains.

In the outer molecular layer the edema seems to have a preference for Henles fibre layer, the fluid appearing in the form of verticle ovals, adjoining the macula where this layer is thickest the separation is greatest; the fibres of the macula are divergent, which causes the interfibrillary spaces to assume an oblique position. The fovea is free from edema, as the molecular layer does not extend over it.

The rods and cones show changes only an half papilla diameter from the disc.

The choroid is normal. The sclera and anterior portion of the eye show no noteworthy changes.

It is a pleasant duty to express my thanks to Dr. Herbert Harlan, from whose clinic this case is reported, for his assistance in the preparation of this paper.

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# RECOVERY IN A CASE OF INFLUENZAL MENINGITIS COMPLICATED BY MENINGITIS.*

*By Thomas F. Satterthwaite, M.D., LL.D., ScD.*
New York City.

While influenza is an affection that spares no organ or tissue of the body, it is usually recognized under one of three types, the respiratory, the gastrointestinal, and the nervous; although, as in the case now to be reported, there is very generally some intermingling of the features of the different types.

In this country, since the great epidemic of 1889, the respiratory type has been the most conspicuous; the others in a less degree and in the order given. In exceptional cases, however, the weight of the disease has fallen upon such special organs as the heart or kidneys, the chylopoetic or the articular system. But it is only of late years that the nervous type has attracted special attention, and even then not so much in its relation to the acute stages of the influenza as to its sequelæ, which comprise a number of nervous disorders, such as motor paralyses or pareses, affections of the special senses, epileptiform seizures, and various mental abnormalities. These sequelæ have sometimes protracted the disease for months, or even years, leaving at times a permanent impression on the affected part. For example, many of us have known of instances where influenzal otitis media has left an incurable deafness, or a suppurating focus in an eye has partially or wholly destroyed the sight.

Less attention, however, has been paid to the nervous phe-

*Read before the American Therapeutic Society at its Fourteenth Annual Meeting, held in Washington, D. C., May 5 and 6, 1913.

nomena which are occasionally features of the acute stage, and which include neuralgias, functional disorders of the special senses, meningitis cerebral or cerebrospinal, and psychic phenomena such as hallucinations, delusions, or even mania, as in this particular case. Of these only a comparatively small number have been reported, many of them with scanty details, so that the profession at large has not had an opportunity to become very conversant with them. On two occasions when I saw such cases in consultation, one being of influenzal cerebrospinal meningitis and the other of the cerebral form, none of the consultants or attendants appeared to have previously seen these particular manifestations. In one, a case of influenzal cerebral meningitis which I saw in Florence, Italy, in the spring of 1893, not one of the other five physicians, representing four different nationalities, had ever seen it, though no doubt was thrown on my diagnosis. The patient recovered, after an unconsciousness of nine days. The patient in the cerebrospinal case died, after an unconsciousness of three weeks. In a third case, in a patient of mine, the subject suddenly developed mania, was removed to the insane pavilion of Bellevue Hospital before I had an opportunity of seeing him, and died there unconscious. As I have already said, such complications are rare; and yet Davis (*Journal of Infectious Diseases,* 10, 1912,) has recently collected sixty cases from the literature and his own experience. Most of these were in children, whose delicate nervous system appears to render them especially sensitive to the toxines of the disease. In fact, most of the reported cases have been in the practice of pediatrists.

Pathologically speaking, the characteristic gross lesions consist of a series of minute hemorrhages scattered throughout the system, often causing such substantial changes in a tissue or organ that its vitality is impaired for a time or forever. And if for any reason the extravasation becomes infected by any of the pus-producing organisms, the prognosis is most unfavorable. Such patients usually die, unless there is free vent for the infected material. The majority opinion is that the disease is due to the influenza bacillus discovered by Pfeiffer, which, though it may not always be found *intra vitam* in the blood or secretions, or even by lumbar puncture, will usually be recovered at post-mortem examination by diligent search, though it may be associated with other microörganisms, such as the pneumococcus or streptococcus, or may be replaced by them. It is a singular fact that it may not always be found in the fresh spinal fluid drawn by lumbar puncture, and a satisfactory explanation of this failure is much to be desired. A plausible theory is that offered by Leichtenstern, who divides influenza into three classes, only one of which is grippal influenza.

There are several methods by which the poison invades the meninges; by extension, as from an otitis media or from abscess of a sinus, by metastasis, or by general infection of the blood by

toxines. That is, in the extension of the disease the poison follows the routes that are pursued by other organisms that produce systemic infection.

Influenzal meningitis is usually ushered in by violent pain in the head, especially in the frontal region and back of the neck, facial neuralgia, and photophobia. There are apt also to be irregular contractions of the pupils, muscular spasms, hallucinations, delusions, unconsciousness, perhaps mania. At first there will be a high pulse rate, perhaps with arrythmia. In the early stages patellar or ankle reflexes are apt to be exaggerated. Later, if there is effusion into the ventricles or at the base, there will be loss of these reflexes, relaxation of the pupils, stupor and slow pulse. Judging from the limited number of cases reported, there is a moderate leucocytosis at this stage. In from six to ten per cent. there is said to be albunimuria, but unless there is profound implication of the kidneys the albuminuria should be short lived. There appears to be seldom any diminution in the number of red cells, or in the amount of hemoglobin, both of which may be increased.

Influenza, we should remember, has been and is one of the most dangerous of epidemics, if we include its complications and sequelæ. Hymansen has collected twenty-six cases of simple or purulent meningitis, associated with influenza (NEW YORK MEDICAL JOURNAL, December 25, 1900), of which five were in adults, with only five recoveries, a mortality of about eighty-one per cent. Pisek has collected fifty-eight cases of influenzal meningitis, which also included five adults, with a mortality of about ninety-two per cent. I have collected a series of forty-four cases of all ages, with nine deaths, a mortality of about twenty per cent. In a second series of thirty-four cases, of which all were adults, there was a mortality of ten, or about twenty-nine per cent.

But the prognosis is very different when to influenzal meningitis pneumonia is added. Usually it takes the bronchial form; in other words, it is lobular, and is disseminated, involving the lower lobes, though any lobe may be affected, and even the whole lobe, as in true lobar pneumonia.* In the case here reported there seemed to be a mingling of the lobar and lobular. Allusion to such cases has been made by Leichtenstern. It started apparently as an extension of a bronchitis, and in the right lower lobe when first detected was apparently a central lobular pneumonia. In the left upper lobe the deposit occupied most, if not all, of the lobe, and presented the usual physical signs of the lobar form. The temperature curve was also that of a fairly well characterized lobar pneumonia. Defervescence occurred on the seventh day. Pneumonia occurring in influenza without meningitis has a

*I was the first to give a comprehensive account of bronchial pneumonia in the adult. The literature had contained only scattered instances of it. I gave twenty cases from my own experience (*British Medical Journal*, December 7, 1889), believing that it merited a classification apart from the bronchial pneumonia of children. All of my cases were proved by post-mortem examinations.

mortality which is extremely variable. Probably a slight pneumonia from an extension of the bronchitis is tolerably common, but the mortality has reached as high as forty-three per cent. On an average, according to my computation, it is about twenty per cent. Davis, in his sixty cases of influenzal meningitis already alluded to, found that in twenty-six that were examined post mortem pneumonia had occurred as a further complication of the influenza in twenty (seventy-six per cent.), but of course in meningitis death may be due to intracerebral effusion, cerebral hemorrhage, abscess, or other causes. In the six out of my thirty-four cases of influenzal meningitis with pneumonia, all I have been able to collect from the literature, five died. In the sixth there was an incomplete cure. The patient (Bury, *British Medical Journal,* September 29, 1900) suffered for two years following the attack from aphemia, that variety of aphasia where there is loss of the power to give the names of persons previously known. The attack also left his mentality affected.

The case I am now reporting is, therefore, so far as I have been able to learn, the only recorded instance of a full recovery in influenzal meningitis complicated by pneumonia. It is as follows:

On March 1 of this year I was called to see a young man, 25 years of age, of good habits and normal physique. During the previous week he had been suffering from prostration, cough, bronchitis and the usual manifestations of a mild influenza (grippe), which had kept him indoors, though he had not called in a physician. On the day before, however, he had exposed himself at an open window in his bedroom. Subsequently, and before I saw him, there had been a chill and violent headache. I found him unconscious, with pupils somewhat irregularly dilated and irresponsive; breathing rapid and labored; temperature by the mouth, 103.5° F.; pulse, 138; respiration, 26. Under moderate doses of the bromides, given at frequent intervals, consciousness partly returned in a few hours, when he again complained of severe headache and pulmonary oppression. He was restless, and had twitchings of the right leg and facial muscles—*i. e.,* clonic convulsions. The bromides were given in increasing amounts, and as there were signs of beginning pneumonia, a hygroscopic, antiseptic poultice was applied to the chest. During this day 110 grains of bromides (bromides of ammonium, sodium and potassium) were given for the convulsive movements and cerebral symptoms. Temporarily, the twitchings were controlled. The pain in the neck and head was relieved principally by ice bags and cold fluid applications.

On the second day the cough, which had been in abeyance, returned, and signs of pneumonia were easily recognized superficially in the left upper lobe and centrally in the right lower lobe. The temperature, which was taken by the rectum, rose to 106° F., the pulse to 120, and the respiration to 40. A blood examination gave white blood corpuscles 27,000; polynuclears, 96 per cent. A very grave prognosis was given. The diagnosis of pneumonia was confirmed by two consultants. During the day 300 grains of the bromides were given.

On the third day there were nausea and vomiting. Highest temperature, 105.2° F.; pulse, 124; respiration, 34. There was moderate hypotension, as shown by the sphygmomanometer, the amount in millimeters on this day and during the acute stage running on an average below the pulse rate. I judged that this low blood pressure was due either to the loss of blood from the minute hemorrhages or to the intoxication from the toxines circulating in the blood; probably the latter.

On the fourth day the highest temperature was 105.4° F.; pulse, 115; respiration, 42. Vomiting of dark fluid and blood, together with the brownish liquid stools, were taken by me to indicate that the gastrointestinal tract was involved, and that there was now an intermingling of the symptoms of the three influenzal types. Calomel, one grain, was now given daily in divided doses, with a high enema. The sputum was rusty and streaked with blood. No influenza bacilli were found in it, but the diplococcus of pneumonia (Frankel's) was discovered. Ten grains of hexamethylenamine were given, dissolved in a pint of water, and 30 grains of this in all were taken during the 24 hours. In addition, strychnine sulphate, in doses of one-sixtieth grain, was given every few hours.

*Fifth Day.*—Highest temperature, 104.9° F.; pulse, 104; respiration, 48. As a heart tonic there was now given a combination of digitalin, strophanthin and glonoin, 1/100 grain of each, every four hours, in addition to the strychnine.

*Sixth Day.*—Low muttering delirium, as of typhoid. Highest temperature, 104.8° F.; pulse, 106; respiration, 40. Bromides given freely, also morphine sulphate, ⅛ grain, and atropine sulphate, 1/150 grain. Petechial eruption on chest. White blood corpuscles, 17,000; polynuclears, 86 per cent.; lymphocytes, 14 per cent. All food refused. Hexamethylenamine suspended. Patient irrational most of the time; mild delusions; hypersensitiveness to sounds; urine normal in amount, but containing a heavy cloud of albumin; involuntary passage of feces. Toward the end of the day the patient took a cup of coffee with milk.

*Seventh Day.*—Camphor, three grains, in aseptic oil, given hypodermically every six hours; strychnine continued. Temperature had fallen to 99.8° F.; pulse, 84; respiration, 24. Patient slept better and took his nourishment; rational.

*Eighth Day.*—Yellowish sputum mixed with blood. Desire for food.

*Tenth Day.*—Camphor hypodermics suspended.

From this date on recovery was rapid and uneventful, the pneumonia resolving quickly. On the seventeenth day the patient sat up in a chair, and on the twentieth was up and about the house. The lungs had cleared and practically all signs of pneumonia had disappeared.

In this instance the temperature followed pretty closely the characteristic curve of lobar pneumonia. It fell abruptly to 99.8° on the seventh day. Lumbar puncture was discussed, but not practised. The diagnosis of influenzal meningitis with pneumonia was made on the first day the patient was seen, so that the presence of the influenzal bacillus as a factor in the diagnosis was negligible. Other reasons against lumbar puncture were that in the adult it had not, in my estimation, proved itself of sufficient curative value; that the liberal use of the bromides in massive doses, together with the cold applications to the head, did give relief to the nervous symptoms; and finally that the influenza bacillus is not always found even in the fresh spinal fluid. The blood pressure never exceeded 110, and was at first below that figure. Milk, with an alkali, usually Vichy water, plain water or albumen water, to which the yolk of a raw egg was sometimes added, constituted practically all the nourishment used during the acute stage. Occasionally an alcoholic was tried, but never more than two drachms at a time, and it was given up altogether during the acute stage, owing to the patient's objection to it. Otherwise vitality was maintained by strychnine and camphor. The usefulness of hexamethylenamine was not evident; it was given for several days, but discontinued on the sixth day. Temperature was

lowered by the cool bath when it exceeded 103°F. The room was maintained at a temperature of 65° to 68°F. with an abundance of fresh air. In general, the treatment was symptomatic, indications as they appeared being met by established therapeutic measures.

In conclusion, I should be lacking in my duty to those who assisted me in this remarkable case if I failed to record my obligations to Drs. W. H. Porter and C. E. Nammack, who saw the patient with me in consultation; to Drs. Morris Carpenter and Allan Carpenter, one of whom was in constant attendance, and to whom, in large measure, I feel that the successful issue of the case was due; to Dr. Mary Halton, who attended to the blood count and bacteriological examinations of the blood and sputum; and to the tact and skill of the eight male and female nurses employed first and last, all of whose services were unusually satisfactory.

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# ADDRESS MADE AT THE PRESENTATION OF A PORTRAIT OF PROF. CHRISTOPHER JOHNSTON, M.D., TO THE MEDICAL AND CHIRURGICAL FACULTY BY HIS FAMILY, APRIL 23d, 1913.

*By H. H. Biedler, A.M., M.D.*

*Mr. President, Fellow Members of the Medical and Chirurgical Faculty:*

Ladies and Gentlemen—It is one of the greatest honors of my life and an opportunity of rare distinction to be permitted to say something upon the occasion of the presentation by his family of the portrait of one of the most classical, polished and highly scientific and distinguished surgeons, not only of the State of Maryland, but of the country at large, of his time, Prof. Christopher Johnston, M. D. Professor Johnston was born in Baltimore September 27, 1822. He was a descendant from Scotch ancestry, his grandfather having been born in Scotland in 1750, and came to Baltimore in 1766, and located here, and since that time the Johnston family have lived in Baltimore. At the age of thirteen he lost his father, and was adopted by his aunt. He was educated at St. Mary's College, in the City of Baltimore, and began the study of medicine in the office of Dr. John Buckler. All of his student life was spent in this city, and part of it in the Baltimore Almshouse. He received the degree of Doctor of Medicine from the University of Maryland School of Medicine in 1844. In this same year he visited Europe. Besides spending much time in the hospitals, he traveled extensively, and in 1848

he joined with Professor Frick and Dr. John Buckler and others in founding the Maryland Medical Institute, an elementary or preparatory school to the study of medicine. In 1853 he again visited Europe, and spent two years studying in the hospitals of Berlin, Vienna and Paris, and on his return to his native city he was appointed lecturer on experimental physiology and microscopy and curator of the museum of the University of Maryland. In 1857 he gave up this position to take the professorship of anatomy in the Baltimore Dental College, which he held until 1864, when he was elected professor of anatomy and physiology in the University of Maryland, which position he occupied until 1869, when he succeeded Prof. Nathan Ryno Smith in the chair of principles, practice and clinical surgery in the University, which position he occupied for twelve years. He had a great influence, and was a powerful factor, and had much to do with the progress and success which the University made during this time. He had, perhaps, a greater influence and did more for the advancement of the University and the study of surgery than any other professor who had ever occupied the chair, and the many students who had the privilege of listening to his lectures and attending his clinics can never cease to remember and appreciate the value of his scholarly instruction and the lucid manner in which he taught his subject and described all surgical operations in detail, and all must have been impressed with his superior ability as an instructor, and, in fact, he was a high type of a modern surgeon and exemplified to the fullest extent the principles which Celsus says a surgeon should possess. "The surgeon should be young, or at least a little advanced in age, with a hand nimble, firm and never trembling, equally dexterous with both hands; vision sharp and distinct; bold, unmerciful, so that, as he wishes to cure his patient, he may not be moved by his cries to hasten too much, or to cut less than is necessary." The typical surgeon should be thoroughly conversant with the knowledge of the Principles of Surgery, possessing the eye of an eagle, the nerve of a lion, and gentle as a woman. Professor Johnston early manifested a strong taste for scientific study and research, and this continued throughout his life. He acquired great expertness with the microscope and was a skillful artist. One of his early papers was upon the "Auditory Apparatus of the Mosquito," and was published in the London Quarterly Journal of Microscopical Science in 1855. He was a frequent contributor to scientific and medical literature, his most extensive work being that on "Plastic Surgery," published in Ashhurst's "International Encyclopaedia of Surgery," 1881. He was painstaking and careful in his operations, ingenious in devising expedients in emergencies, and paid more than usual attention to detail and cosmetic effect. He was the first in Maryland to perform complete Extirpation of the Upper Jaw, in 1873, and also Exstrophy of the Bladder, in 1876, Prof. John Eric Erichsen, of London, being present, which opera-

tion I had the pleasure to see him perform. During my student life I had the opportunity of seeing him perform many Trachectomies, as well as a number of other capital and minor operations. He was a man of great wit, which, in addition to his scholarly manner of treating a subject, would make it always most pleasing and interesting by some apt illustration or witticism. For instance, in one of his clinics one day he was operating upon a patient for what he diagnosed at the time as a case of Inguinal Hernia, and before he began the operation he gave us a long dissertation upon the importance of carefully investigating each and every case and by a process of reasoning, known as exclusion, must exclude the most improbable things until we came to the most probable and then proceed to perform the operation, whereupon when he cut down upon the supposed Hernia it proved to be a third Testicle, when he said to the class: "Gentlemen, this only illustrates the great care which should be exercised in making your diagnosis and emphasizes an important factor that you must leave no stone unturned." And there are a number of other incidents in my student life at the University where his great brain and sharp wit served to amuse the students and make our work one of real pleasure, and I have often thought if I had only made note of all his witticisms during the two years which I had the pleasure to listen to him lecture, it would be a most readable and valuable volume. He was devoted to his profession and was a great surgeon, a hard student and ideal teacher and man, and enjoyed a reputation in his chosen profession second to none. He was ever ready to protect and promote in every way the demands of his profession. He assisted in founding most of the societies in our city and State, and held the presidency in all the important local ones, including the Maryland Academy of Sciences, the Medical and Chirurgical Faculty, and he was consulting surgeon of the Johns Hopkins when it opened and other hospitals. He took a deep interest in the Johns Hopkins University, its museums and laboratories, and on his death bequeathed to it his medical and surgical instruments, his microscopical cabinet, his cabinet of crystals and library. Succeeding Professor Smith in the Chair of Surgery in the University of Maryland, he also succeeded him in his leadership in his profession, and from 1870 to 1890 he was unquestionably the head of the profession in this city and State. He visited Europe five times, on the last occasion in 1886, traveling through Russia, Norway and Sweden, and was, perhaps, better acquainted with the leading members of the profession throughout the world than any other American of his time, and upon many occasions I have known of his entertaining foreign members of his profession, all of whom held him in the highest esteem. He was thoroughly familiar with the Latin, Greek and French languages, speaking all of them fluently. He was a man of striking appearance, as his portrait so well shows, having a commanding and erect figure, graceful carriage, classical head

and small features, and always neatly attired and a man whose speech was always formal and his sentences well rounded, and, in fact, the highest type of surgeon known to his time. He was a highly professional gentleman and had a special consideration and respect for the students and younger members of the profession, and it is not any wonder that we should upon this occasion pay tribute to him and wish to have his portrait occupy a conspicuous place upon the walls of the Medical and Chirurgical Faculty, where it may be an inspiration and guiding star to all of those who may have an opportunity to look upon such a "Magnus Apollo" as he was, which we all wish to honor and perpetuate. Professor Johnston married Miss Sarah Smith, of Washington, D. C., in Christ Church, October, 1855; they were married by Rev. Joshua Mussell, and from this union five children were born, four sons and one daughter. Mrs. Johnston died July, 1879, and Professor Johnston died October 11, 1891, from Acute Indigestion—whatever that may have meant at that time I do not know—and was buried in Loudon Park Cemetery, Baltimore, Md. All five of his children are living and occupy prominent places. His son, Dr. Christopher Johnston, received the degree of Doctor of Medicine from the University of Maryland School of Medicine in 1880, and was elected Associate Professor of Oriental History and Archaeology of the Johns Hopkins University in 1899, which position he occupied until 1900, when he was elected full Professor; he also received the degree of LL.D. from the University of Maryland, 1910. His son, Morris Johnston, has been a prominent journalist for many years and is well known. His other two sons occupy prominent positions in the commercial world, all of which reflects great credit upon their parents. And in behalf of his family I wish to present his portrait, that it may occupy a place amongst those of the other distinguished members of the Medical and Chirurgical Faculty.

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The Doctor In Court. By Edwin Valentine Mitchell, LL.B., of the Massachusetts Bar. New York: Rebman Company. 1913. Cloth, $1 net.

Doctors, being otherwise engrossed, have given too little attention to the legal aspect of their profession. The purpose of the above book is to give a succinct account of the law as it applies to physicians and surgeons. This it does exceedingly well. It deals with an aspect of the subject seldom touched in books, and a thorough knowledge of its contents would in many instances prevent unpleasant eventualities. It deals with the side of law which embraces professional evidence, the contract of the profession, civil responsibility of the profession, remuneration, confidential communications, the criminal responsibility of the profession, etc. It will be found when needed a handy companion to have around.

# THE PSYCHIATRIC CLINIC AND THE COMMUNITY.*

*By Stewart Paton, M. D.,*
Princeton University.

THE increasing interest shown in the study of human activities is one of the most significant and hopeful signs of our times. Momentous as was the impulse given to science by Copernicus, Galileo and Newton, one result of their investigations was to direct attention to an universe in which human beings were considered to be merely passive observers of natural phenomena. So absorbed did man become in formulating hypotheses to explain a theoretical universe of which he did not form a part, and in delving into the records of his own past history, he neglected the study of present activities. At last the course of events warned him that the lessons of remembrance or the hypertrophied historical sense had become "a malady from which men suffer."

The dedication of a psychiatric clinic is an event of more than ordinary importance to a community, as it marks the awakening of intelligent interest in man as an active thinking being. Having striven for centuries to improve the methods for recording his fanaticisms, superstitions, sins of omission and of commission, and failures to adjust life to meet new conditions, he has begun at last to take rational measures to improve his lot, and to acquaint himself with the laws on which the social organism rests. As the value of this benefaction to the community will depend directly upon the intelligent use of resources and energy made available for rendering more effective service to humanity, may we not profitably devote a few moments in attempting to formulate some of the problems to the solution of which this clinic is dedicated? Errors in judgment committed now in estimating the scope and the character of the investigations to be carried on in this building might defeat the efforts of those upon whom the responsibility of equalizing opportunity and achievement must fall.

This clinic in a peculiarly distinctive manner typifies the human as well as the humane spirit of the twentieth century. During the seventeenth and eighteenth centuries the physical sciences had succeeded in breaking away from the traditions and superstitions which had hampered their development. Astronomy had been divorced from astrology, chemistry from alchemy, and the foundations of geology had actually been laid. In the nineteenth century the renaissance of the biological sciences was accompanied by the formulation and expression of a rational idea of man's position in cosmos. Towards the close of the eighteenth and the beginning of the nineteenth century a few investigators had already called attention to the importance of studying the activi-

*Address delivered at the opening exercises of the Henry Phipps Psychiatric Clinic, the Johns Hokpins Hospital, Baltimore, Md., April 16, 1913.

ties of human beings, but not until the second half of the last century was there any realization of the fact that the most interesting phenomena of the universe for human beings to study were their own activities. How do we live, move and have our being?

To the lay mind the term Psychiatry often suggests a very limited field in medical science, but those who take an active part in the work of this clinic will easily appreciate that they are engaged in attempting to find the solution of problems of far greater importance than any relating merely to the care of patients suffering from mental or nervous disorder. Anomalies of thought and conduct are studied in order that the knowledge acquired may be applied directly to making life for the majority of persons pleasanter and more effective. Institutions of this character are intended primarily for the study of human nature along broad biological lines.

We are justified in considering disease as an analytical process which reduces to a comprehensive form the complex activities we designate collectively as health. An intimate knowledge of abnormal states of mind and body is, as Pinal affirmed, a key that unlocks the secrets of human history. By making use of nature's contrast of functions we may also gain an insight into that continuous process of adjustment we call life. From the study of disease the facts have been gathered for the foundations upon which modern preventive medicine has been established, and through it a new meaning has been given to life and greater efficiency in thought and action to those who profit by the lessons of science. For centuries the different parts of the body have been studied by physicians, and a knowledge of the structure and function of the separate parts has been attained. It is essential, if we are to comprehend the fundamental mechanisms of response of the organism, that we familiarize ourselves with the laws which govern the relationship of all these organs as they are expressed in each individual; and we must accustom ourselves to study man as a living organism.

Living beings have the capacity of expressing their integral unity as individuals, and in the case of man there are special mechanisms of adjustment, collectively designated as the personality. The complex adjustments synthesized in the personality may easily be deranged by interference with the activities of organs, or by disturbing the capacity for adapatation; the chief function of sense organs, brain and nervous system. We all know how intimately dependent human beings are upon their environment. Changes in the latter call for delicate and immediate adaptation, and it may be said the problems of phychiatry relate to the determination of the causes which give rise to imperfect adjustments. A great blessing was conferred by science upon humanity when the problems of psychiatry were restated in biological terms. Life was recognized as a process of adjustment, relatively perfect in health and imperfect in disease; while

that metaphysical term insanity, arbitrarily reserved to designate certain forms of unsuccessful adjustment, was cast into the rubbish heap, together with the chains, strait-jackets and handcuffs which had long tortured the lives of patients. Out of the hazy, mystical conceptions entertained in regard to the nature and genesis of activities described as thought and conduct sprang new ideas potent to inspire the minds of investigators, capable not only of bringing about great practical reforms in the care of the insane, but also in improving the methods for attacking the problems relating to human thought and conduct.

As the ultimate success of the work to be carried on in this clinic, more than in any other department of the hospital, will depend upon co-operative endeavor, I may be permitted to emphasize what seems to me to be an important factor in organization and administration. The patients presenting themselves for treatment are subjects of imperfect adjustments in the life process. The time during which they remain under observation in these wards will represent relatively brief epochs of life, and the records of cases will often give but cursory glimpses into the genesis, duration and progress of imperfect life adaptations. In order to serve the high purpose for which it is planned and dedicated, this clinic should be regarded as an important link in a chain of agencies, home, school, college, other hospitals and institutions; in fact, the entire social organization with which it is essential constant sympathetic contact should be maintained. Only by the establishment of these relationships can progress in the study of life processes be made.

May we express the hope that in attempting to estimate the value of the work accomplished in this Clinic the public expression of opinion should be tempered by charity and patience. Although the field of investigation, which includes the consideration of the factors determining human thought and conduct, is the most interesting one in modern medicine, let us not forget that it is the last one to be thrown open to investigators.

The methods of investigation necessarily employed will not appeal to the imagination of the public. The inspiration essential to solve the problems of modern psychiatry will probably not flash into consciousness as did the visions that guided the observer watching the lamps swing in the cathedral or the apple fall from the tree, but it will come gradually only after patient, quiet effort, similar to that which finally rewarded the author of "The Origin of Species," and gave a new meaning to life. The realization of the ideals to which we do homage today will mark the time when, in Goethe's words,

> "Vernunft fängt wieder an su sprechen,
> Und Hoffnung wieder an zu blühn."

## Correspondence.

### ARMY MEDICAL CORPS EXAMINATIONS.

The Surgeon-General of the Army announces that preliminary examinations for appointment of First Lieutenants in the Army Medical Corps will be held on January 19, 1914, at points to be hereafter designated.

Full information concerning these examinations can be procured upon application to the "Surgeon-General, U. S. Army, Washington, D. C." The essential requirements to secure an invitation are that the applicant shall be a citizen of the United States; shall be between 22 and 30 years of age, a graduate of a medical school legally authorized to confer the degree of Doctor of Medicine; shall be of good moral character and habits, and shall have had at least one year's hospital training as an interne after graduation. The examinations will be held simultaneously throughout the country at points where boards can be convened. Due consideration will be given to localities from which applications are received, in order to lessen the traveling expenses of applicants as much as possible.

In order to perfect all necessary arrangements for the examinations, applications must be completed and in possession of the Adjutant General at least three weeks before the date of examination. Early attention is therefore enjoined upon all intending applicants. There are at present 26 vacancies in the Medical Corps of the Army.

Chas. M. Gundy,
*Colonel, Medical Corps. U. S. Army.*

## Book Reviews.

Collected Papers by the Staff of St. Mary's Hospital. Mayo Clinic. Rochester, Minnesota. 1912. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Company. 1913.

A word from us is hardly necessary to impress upon the surgical members of the profession; indeed, the medical, the urgent necessity of possessing the yearly issues of the Collected Papers by the staff of St. Mary's Hospital, Mayo Clinic, Rochester, Minnesota. Here some of the most advanced medical work is being carried out, and the result published helter-skelter throughout the literature, so one desiring the same in convenient form must of necessity resort to the yearly publications. As in most clinics, so here there are certain lines which are most prominent; especially do we note the work being done in gastro-intestinal and thyroid surgery. Other ductless glands which have come in for considerable notice are the spleen and the thymus gland. Especially is this

true of the spleen, to which considerable effort, time and space has been devoted. The work upon the kidney at this clinic should also attract the attention of the advanced and progressive surgeon. One notes with more than passing interest that, unlike formerly in nephrectomy for tuberculosis, where drainage was invariably advised, the Mayos advocate closure of the wound without drainage, thus obviating the likelihood of sinus formation with tedious healing. Speaking of this condition, W. J. Mayo says: "A case of this type came under our observation. In operating a large accumulation of whey-like fluid was found outside of the kidney, and, after removing the kidney, treating the ureter and cleansing the wound as well as possible, the cavity, which held more than a quart, was filled with normal salt solution, and closed without drainage. The patient was greatly debilitated, and had a moderate lesion of the remaining kidney. Primary union and a prompt and permanent recovery followed. * * * Since then, in operating on these cases, if the wound be soiled with tuberculous material, the cavity is cleansed as well as possible, filled with normal salt solution, and closed without drainage. * * * In cases in which the tuberculous material has not escaped into the wound, and the patient is otherwise in good condition, there is, of course, no necessity for using the salt solution, but drainage should not be employed." Charles H. Mayo and B. F. McGrath summarize their observations upon the thymus thus:

1. The thymus is an organ of internal secretion, and of essential importance in the vital process of the body.

2. The combination of epithelium reticulum and lymphocytes indicates that its structure is composed of two parts, which are embryologically, morphologically, and also physiologically different.

3. The life of the gland consists of two phases,—one of progression, the other of regression,—but the old view, namely, that the thymus completely disappears, is now considered erroneous. Remnants of thymic tissue are commonly observed in old age, consequently the expression persistent thymus should be dropped. In this relation Hammar favors designating the normal, subnormal and supranormal parenchymatous value of the gland, which seems a scientific advancement in its description. The stage of physiologic regression probably begins about the time of puberty, but the gland frequently undergoes a pathologic involution, the effect of infectious diseases, inanition, exhaustion, etc. X-rays cause a similar result, affecting principally the lymphocytic elements of the organ.

4. Experimental extirpation of the thymus seems to prove that it is an important organ during the period of active growth; that its function is concerned with general development, and particularly with the ossification of bone. Resultant changes are noted in various structures throughout the body in the early period of life. Alterations of the mental state, acid intoxication, and

severe cachexia have been observed co-existing with thymic deficiency.

5. Evidence indicates that the secretion of the thymus acts antagonistically to adrenalin. The co-relationship of the thymus with the thyroid appears to be co-ordinative.

6. The mechanic theory of sudden death seems to have been too frequently applied. Whereas thymic pressure may be the causal factor of death in some cases of helpless infants, in strong children and adults it is now practically excluded. In some of the reported cases capillary bronchitis and intestinal disease have been noted in association with the enlarged thymus. Since death has been observed to occur suddenly in these conditions, their causative importance or their presence must be excluded before considering the death thymic. That the enlarged thymus can mechanically cause respiratory and circulatory disturbances seems to be strongly supported by clinical observation plus immediate operative relief. In the presence of such clinical pictures in children the possibility of thymic pressure should always be considered. In cases of sudden death, where the thymus is found enlarged, and respiratory, intestinal, and other serious diseases are excluded, the chromaffin system should be examined for insufficiency. The possibility of status thymico-lymphaticus should not be overlooked; the various peculiarities of this condition should be sought.

7. The casual importance of thymic enlargement alone in serious disturbances and death is still a debatable question. Assuming the frequent coexistence of thymic hyperplasia with goiter, which is maintained by several, the statistics of mortality, cure and relief following operations on the thyroid do not seem to support the significant role ascribed by some to simple enlargement of the thymic gland.

8. Recent studies indicate that status thymicus, status thymicolymphaticus and status lymphaticus are to be separately considered. The anatomic diagnosis of genuine status thymicolymphaticus in very young children is at present impossible—at least, extremely difficult. The lymphatic system of the child is very sensitive to irritations, such as diseases of the intestinal tract, etc. A sharp distinction must be made between lymphatism of congenital origin and acquired lymphatism. The former presents organic changes which are closely related to the status hypoplasticus of Bartel and the eunuchoid type of Tandler and Grocz. The acquired form is, in the majority of cases, the effects of previous infections or autointoxications. It is also said to result rarely through correlation with other irregularly functionating glands of internal secretion. Despite some clinical reports, the fact remains that our chief knowledge of status lympathicus is of the changes observed at autopsy. The disease is comparatively rarely diagnosed during life. This emphasizes the need of those doing autopsies constantly to make observations with the object of deter-

mining signs available for the clinician. Shriddle, in a recent paper, has emphasized this point. This author states that in all of his autopsies where this condition was present there was a hyperplasia of the lingual follicles. He emphasizes this finding both because of its constancy and also because these follicle are rarely inflamed. The signs observed by V. Neusser, which are cited under status thymicolymphaticus in this paper, should be kept in mind.

9. The recent observations which have been made on the association of status thymicolymphaticus with Addison's disease and exophthalmic goiter deserves careful consideration. This seems to be a fertile field for investigation.

10. Operative treatment of the enlarged thymus has given the best results. It is comparatively easy, controllable, and relief is practically immediate. Tracheotomy is usually futile. Drainage should be avoided if possible. Intracapsular thymectomy is the operation of choice.

The deductions drawn from observations made upon diseases of the spleen, which are presented in several articles, are also well worth spending some little time and thought upon. In this section W. J. Mayo has a short article on the Surgery of the Spleen, at the end of which he tabulates the series of cases operated on at St. Mary's Hospital, according to clinical diagnosis and after results.

The volume is an exceedingly important collection of well-prepared papers, and should prove as useful to the profession as its predecessors.

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THERAPEUTICS OF THE GASTRO-INTESTINAL TRACT. By Dr. Carl Wegele. Adapted and Edited, With Additions on the Diagnosis of the Diseases of the Esophagus; Diagnosis of the Diseases of the Gastro-Intestinal Tract; Duodenal Tube and Its Uses; Diseases of the Pancreas, and X-Ray Examinations of the Gastro-Intestinal Tract. By Maurice H. Gross, M.D., Attending Gastro-Enterologist to the Har Moriah Hospital, and I. W. Held, M.D., Attending Physician to the Har Moriah Hospital. With 52 Illustrations in the Text and Two Figures in Colors on One Plate. New York: Rebman Company. 1913.

Those looking for a practical, as well as thorough, treatise on diseases of the gastro-intestinal tract will find Wegele's book meeting their requirements. Why? Because the author is a past master in making concise statements, and in summing up as concisely and neatly the present status of gastro-enterology as anybody we know. The translators are to be congratulated, not only upon excellent rendition of the original into English, but also their many additions to text, which has increased the scope and value of the work. Among these additions are chapters on the diagnosis and treatment of diseases of the esophagus, a very im-

portant part of the human economy, but until recently thought to be heir to but few affections; X-ray diagnosis of diseases of the stomach and intestines, a modern development with which all physicians should be familiar; also a chapter upon the duodenal tube, an indispensable agent in clearing up duodenal affections, etc. Undoubtedly, the book is a book for the general practitioner, who will find it to be written along scientific lines, full of useful suggestions, and placing sufficient weight upon dietetic and hygienic treatment.

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The Surgical Clinics of John B. Murphy, M.D., at Mercy Hospital, Chicago. August, 1913. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Company. Published bi-monthly. Paper, $8 per year.

Volume 11, Number IV, of The Surgical Clinics, as many of its predecessors, contains mostly Dr. Murphy's observations on the work which he is most interested in at present, namely bone surgery. Under this category he discusses the blood supply in and around the joints, fixation of knee with backward luxation of the tibia, fracture of the femur above condyles, with non-union and overriding of the patella by the lower end of the upper fragment, tumor of the radius, ankylosis of knee-joint, with hyperextension of the leg and excessive production of bone subperiospeally-acute infection in joints; formalin-glycerine treatment, pseudarthrosis of shaft of humerus-ankylosis of elbow-wrist drop, bony ankylosis of jaw, with interposition of flaps from temporal fascia, ununited fracture of the tibia; removal of silver wire; bone transplantation, non-union of fractures-causes, old ununited fracture of the tibia-transplantation of bone and laminectomies for various spinal affections. As Dr. Murphy is doing the most advanced work in bone surgery, his observations, operative technic and ultimate results should be of interest to every surgeon. He has the facility of easy and attractive statement of observations, in short, crisp English without the many flourishes of many writers, which renders the clinics more useful than they would otherwise be. What he has to say he says with as few words as possible, then the subject is dismissed. It is this feature which has made his writings so popular. The present volume will be found no exception to the rule.

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International Clinics. Volume 1. Twenty-third Series. 1913. Philadelphia and London: J. B. Lippincott Company. Cloth, $2 net.

The wideawake physician can in no manner keep better abreast of the times than by reading the International Clinics. It supplies just what he needs, and in such form as to consume the least possible time compatible with an intelligent understanding of the

topic under discussion. Volume 1, twenty-third series, contains such live articles as: The treatment of poliomyelitis, clinical symptoms and diagnosis of gall stones, the diagnosis and treatment of scarlet fever, intestinal auto-intoxication, retarded mental development in children, report of ten cases operated upon for Pott's disease of the spine by Albee's method of bone grafting, transplantation of tissue, care of woman through her thirty-nine weeks of gestation, etc. As can be determined from the variety and character of the foregoing, this periodical is deserving of the best consideration by the medical profession.

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A Course in Normal Histology. A Guide for Practical Instruction in Histology and Microscopic Anatomy. By Rudolf Krause, A.O., Professor of Anatomy at the University of Berlin. Translation from the German by Philipp J. R. Achmahl, M.D., New York. With 30 illustrations in the Text and 208 Colored Pictures. Arranged on 98 Plates After the Original Drawings by the Author. Part II. New York: Rebman Company. Cloth, $5.50 net. 1913.

Part II of Krause's Histology deals exclusively with histology pertaining to medicine, and can be obtained separately if desired. It serves as an excellent reference book to students engaged in the study of minute anatomy, and is full of handsome, as well as true to nature, illustrations, both tinted and untinted. The cell is first considered, then in order the tissues of the animal body (epithelium, connective tissue, cartilage, bone, muscle, nerve tissue, blood), organs (circulatory, the glands, organs of digestion, of respiration, genito-urinary, of motion, of the nervous system, of sense and the skin). This arrangement is ideal, and should give the student a proper start and insight into histology. The right start means so much, especially so in medical studies. Therefore, anything which tends to simplify the grasp of medicine meets with our greatest commendation. This work is of that character, the arrangement being simplicity itself, and should usher the student into the intricacies of histology with the least possible shock.

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Müller's Serodiagnostic Methods. Authorized Translation from the Third German Edition. By Ross C. Whitman, B.A., M.D., Professor of Pathology, University of Colorado School of Medicine. With Seven Illustrations in Text. Philadelphia and London: J. B. Lippincott Company. 1913. Cloth.

Those interested in this phase of medicine will find Whitman's translation of Müller's Serodiagnosis remarkably smooth reading as well as accurate rendition of the original. Serodiagnosis has made during the past few years such strides that it is indeed difficult to keep in touch with the subject, besides the articles are usually so technical that the ordinary individual does not know what the author is driving at. This booklet is divested of techni-

calities as far as feasible, in order to bring it within the grasp of the general practitioner. It deals with the methods of injecting animals, of obtaining blood from animals, of obtaining small amounts of human blood, of obtaining larger amounts of human blood, of the preservation of sera, both normal and immune, of precipitin, agglutination, etc., reactions, and syphilis, cancer, gonorrhoea and tuberculosis diagnosis. It is based upon the wide experience of Dr. Müller in this line of work, is authoritative, and deals with the subject from the practical side, theoretical discussions being entirely omitted.

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Laboratory Methods. With Special Reference to the Needs of the General Laboratory Methods. With Special Reference to the Needs of the General Practitioner. By B. G. R. Williams, M.D., Member of Illinois State Medical Society, American Medical Association, etc. Assisted by E. G. C. Williams, M.D., formerly Pathologist of Northern Michigan Hospital for the Insane, Traverse City, Michigan. With an Introduction by Victor C. Vaughan, M.D., LL.D., Professor of Hygiene and Physiological Chemistry and Dean of the Department of Medicine and Surgery, University of Michigan, Ann Arbor, Michigan. Second Edition. Illustrated With 43 Engravings. St. Louis: C. V. Mosby Company. 1913. Cloth, $2.50 net.

Like its predecessor, Williams and Williams' Laboratory Methods is neither a compend or exhaustive textbook. Nevertheless, the general practitioner will find this second edition to greatly facilitate and simplify their efforts in making the general routine laboratory examinations. It is especially adapted to those of limited equipment who have neither experience for, intricate technic or the finances for expensive laboratory equipment. Such conditions have ofttimes discouraged the general practitioner from attempting his own laboratory work, a state of affairs which the present volume, as well as its predecessor, point out should not be, as accurate and reliable work can be done in many instances with inexpensive apparatus. Those members of the profession desiring an accurate, simple, trustworthy guide of sufficient fullness to easily and comprehensively convey the ideas of the authors will find such in the above-mentioned volume.

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Catalogue—Medical, Surgical and Dental Books. 1913. St. Louis: C. V. Mosby Company.

C. V. Mosby's descriptive catalogue of their medical, dental and surgical publications is just off the press. It contains a complete list of their most recent publications, besides numerous illustrations culled from their publications. The firm will gladly send a copy to anyone interested, free of charge, on request.

# MARYLAND MEDICAL JOURNAL

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BALTIMORE, DECEMBER, 1913

## A MUNIFICENT GIFT.

LAST month, just as the JOURNAL was about to come off the press, we were gratified to learn through newspaper announcement that the Johns Hopkins Medical School had been granted by the General Education Board $1,500,000 for the purpose of putting the three clinical departments—surgery, medicine and pediatrics—on a full-time, full-paid basis. It is the opinion of the Board that at least the heads of these departments should devote their entire attention to teaching and research work, and not be bothered with the necessity of making a living from their private practice. The members, therefore, appropriated a million and a half for the purpose of giving their theory a test, and as a pretty compliment decided upon the Hopkins as the best suited medical school in which to make the test. There are many things which can be said in its favor, some against, but on the whole the movement seems to be a step in the right direction. To our way of thinking, a medical school should have three sets of professors—the investigator, the teacher and the practical clinician. Occasionally, but only too rarely, one man combines all these qualities; therefore the best method in which to furnish all the above requisites is to appoint three separate men, each one peculiarly fitted for his field. It will doubtless be more than gratifying to his many friends, both lay and professional, to learn that the foundation is to be called the William H. Welch Endowment. No man is more deserving of the honor. For more than 25 years Dr. Welch has given his best effort to the upbuilding and creating of new policies at the Johns Hopkins University medical school, but latterly and in conjunction with his multifarious educational responsibilities he has found

time to identify himself with not only municipal problems, but also State and National ones. It is therefore befitting that this modest, most lovable of men should be accorded such a signal honor. We congratulate Dr. Welch in behalf of the readers of the JOURNAL in having his name linked with the gift.

The scope of the gift and the reasons therefor are fully set out in the following formal statement:

> The General Education Board announces that it has appropriated a sum approximating $1,500,000 to the Johns Hopkins Medical School, which is a part of the Johns Hopkins University, for the purpose of so reorganizing the departments of medicine, surgery and pediatrics that the professors and their staffs in these departments will completely withdraw from paid practice in order to devote their entire time to the care of patients, teaching and research in their respective departments.
>
> In explaining the object of this gift, Mr. F. T. Gates, chairman of the General Education Board, makes the following statement:
>
> "Since the opening of the Johns Hopkins Medical School in the early nineties it has been universally conceded that the teaching of the underlying medical sciences, namely, anatomy, physiology, biology, pathology and pharmacology, must be placed in the hands of men devoting their entire time to teaching and research in their subjects. As the clinical branches are more extensive and more complicated than the above-mentioned underlying sciences, the medical faculty of the Johns Hopkins University has become convinced that it is fully as important that the clinical subjects should be cultivated and taught by men freed from the distraction involved in earning their living through private practice."

As yet the trustees of the Hopkins are not aware if any or all of the heads of the departments affected will accept the provisions of the gift. They do know that it would work a handicap upon some, who have suited their style of living to their income—their present appetites being greatly in excess of the income from the fund. It may be, therefore, that one or more may not see his way clear to accept the conditions of the Foundation, namely, that he accept no personal fee, whether he sees a patient in the hospital or outside; otherwise the participant in the gift is absolutely free as to how he uses his time.

The medical profession awaits with expectancy the outcome of the reorganization. The question is, Will the returns in the way of new discoveries and more efficient teaching be sufficiently large to warrant such a large investment? Time alone will tell. We hope it will.

## Medical Items.

Dr. Andrew C. Gillis, Physicians and Surgeons, '04, announces the removal of his office to 914 N. Charles street.

Dr. Nathaniel G. Keirle, chief of the Pasteur Institute, city post-mortem physician and the "grand old man" of the medical profession of Baltimore, of 1419 W. Lexington street, celebrated his eightieth birthday October 10, 1913. He was the guest of honor at the University Club at a dinner given by a number of physicians connected with the College of Physicians and Surgeons, at which Dr. Harry Friedenwald was toastmaster.

Dr. Benjamin H. Swint, Physicians and Surgeons, '11, resident physician at St. Joseph's Hospital, has resigned to take effect November 1. He will return to Virginia and plans to take up practice there. Dr. Edward F. Johnson, one of the assistant residents, has been named as Dr. Swint's successor. Dr. Johnson's successor has not been named.

As the editors of *Old Maryland* have been unable to get a complete mail roll of the subscribers thereto, they would appreciate it if all those who did not receive copies of the November issue would send their names and addresses to No. 608 Professional Building, Baltimore, Md.

Dr. Brice Goldsborough, who was recently a patient at Dr. Howard A. Kelly's Sanitarium, Baltimore, has recovered and resumed his practice.

Sir William Osler has accepted an invitation to deliver the principal address at the opening of the James Buchanan Brady Urological Clinic in the spring.

As a delegate from America Dr. Henry Barton Jacobs attended the formal opening of the International Tuberculosis Conference in Berlin.

The request of the Baltimore hospitals for an increased per capita of 50 cents per patient has been refused by the Board of Estimates. For many months there has been a movement on foot to have this raised to $1.00, the hospitals contending that under the present arrangement they were suffering a loss. There are at the present time 11 hospitals under contract with the city to care for patients who are turned over to them either by some branch of the city charities or representatives of the Police Department.

Dr. Adolph Meyer, director of the Phipps Psychiatric Clinic, has returned from abroad.

Dr. Adolph Schmidt, privy councilor to the German Emperor and professor of medicine in the University of Halle, Germany, had conferred on him the honorary degree of LL.D. by the University of Maryland, November 11, 1913. While in Baltimore Dr. Schmidt was the guest of Dr. John C. Hemmeter at his home on University Parkway.

The State Board of Health, Dr. William H. Welch, president, which has been located on East Franklin street for several years, has moved to the Frank Brown Building on Saratoga street. The board will occupy the second and third floors of the building.

Dr. Frank G. Moyer, Physicians and Surgeons, '81, of 1500 Eutaw Place, who was recently hurt in an automobile accident, has recovered and is able to be out again.

Dr. C. W. G. Rohrer, acting chief of the Bureau of Communicable Diseases of the State Board of Health, was painfully, though not seriously, injured recently by dislocating his shoulder while opening a street car door.

The Baltimore friends of Dr. Samuel Taylor Darling, Physicians and Surgeons, '03, general pathologist of the Canal Zone, are especially interested in his appointment as consulting expert at Johannesburg, South Africa, where he will be called upon to lay down new rules for the sanitation of that city.

Dr. Guiseppe Bastianelli, one of the noted physicians and teachers in medicine of Rome, Italy, paid a recent visit to Baltimore. While in the city he stopped at the Stafford. He was the guest at dinner of Dr. William S. Thayer and at luncheon of Dr. Lewellys F. Barker.

A meeting of the National Academy of Sciences was held at the Johns Hopkins University, November 18 and 19. Dr. William H. Welch, head of the administrative committee of the Johns Hopkins University, is president of the Academy, which is composed of about 150 of the leading scientists of the United States. Dr. Joseph S. Ames is chairman of the committee on arrangements.

Dr. Martin F. Sloan, superintendent of Eudowood Sanatorium, near Towson, has been granted leave of absence for three months to accept an invitation to go to the tuberculosis

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sanatorium of the Marine Hospital service at Fort Station, N. M.

The home of Dr. Alfred T. Gundry, near Catonsville, Md., was recently entered by thieves. The burglars forced a window on the first floor, and both the first and second floors were ransacked while the occupants slept, though no articles of value were missing.

Dr. John Ruhrah, Physicians and Surgeons, '94, secretary of the Medical and Chirurgical Faculty of Maryland, formerly of 839 N. Eutaw street, has removed to 11 E. Chase street. His practice is limited to the diseases of children.

The musicale by the Doctors' Orchestra, for the benefit of the Book and Journal Club, was held at 1211 Cathedral street, Tuesday, November 11, 1913.

A tuberculosis dispensary, in connection with the Annapolis Emergency Hospital, has been formally opened. It is in charge of Miss Anne Doyle of Baltimore. The Nurses' Training School, an adjunct of the hospital, established three years ago, will hold its first commencement in December. It is thought that Governor Goldsborough will deliver the address.

Dr. Gilbert Horrax, Johns Hopkins Medical School, '13, of Montclair, N. J., interne in Brigham Hospital, Boston, was one of the ushers at the Wilson-Sayre wedding on the 25th inst. Dr. Horrax is well known in Baltimore and is the best all-around track athlete on the Hopkins records for the last several years.

Dr. James Farnandis Mitchell, Johns Hopkins Medical School, '97, and Mrs. Mitchell, of 1344 19th street N. W., Washington, D. C., formerly of Baltimore, started recently on the Niagara for a trip around the world. The first stop will be in Bermuda, whence they will go to England. The winter will be spent in the Mediterranean and Egypt. The Niagara is a private yacht owned by Mr. Howard Gould, and has made a former trip around the world.

The Medical Association of Harford County met recently and elected the following officers: Dr. J. Lee Hopkins of Havre de Grace, Md., president; Dr. Jay H. Stier of Perryman, Md., vice-president; Dr. Charles Bagley of Bagley, Md., secretary.

The Washington Society of Nervous and Mental Diseases have inaugurated their seventh session by re-electing last year's officers, as follows: President, Dr. Tom A. Williams; vice-president, Dr. W. M. Barton; secretary, Dr. W. M. Hough. The society has a limited membership, but welcomes physicians and surgeons interested in neurology and psychiatry. It meets monthly on the third Thursday at the Cosmos Club or a member's residence.

Dr. Tom A. Williams has returned from spending the summer in Europe.

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### MARRIAGES.

John Guirley Missidine, M.D., University of Maryland, '11, to Miss Sara Taft, both of Parsons, Kan., at Parsons, October 15, 1913.

Randolph Grimm, M.D., Johns Hopkins Medical School, '08, surgeon, U. S. P. H. S., of Savannah, Ga., to Miss Heloise Percifull of Fredericksburg, Va., at Fredericksburg, November 12, 1913.

Maurice I. Stein, M.D., University of Maryland, '09, of Millerstown, Pa., to Miss Sarah Rubin of Baltimore, Md., at Baltimore, September 13, 1913.

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### DEATHS.

Clara E. Query, R.N., University Hospital Training School for Nurses, class of 1906, formerly of Charlotte, N. C., president of the University of Maryland Nurses' Alumnae Association, for three years secretary of the Maryland Association of Graduate Nurses and a member of the Red Cross Society, died suddenly at Glitner Hall, Goucher College, this city, November 4, 1913, aged 50 years.

George L. Lee, M.D., College of Physicians and Surgeons, '82, of Center Hall, Pa., died at his home from carcinoma of the liver, August 7, 1913, aged 60 years.

Morris Ramsey Bowie, M.D., University of Maryland, '08, of Somerset, Colo., died in Los Angeles, Cal., October 21, 1913, aged 27 years. Dr. Bowie was a Fellow of the American Medical Association and a prominent practitioner of Gunnison county, Colorado.

Arthur Adelbert Downs, M.D., Baltimore Medical College, '97, of Fairfield, Me., died at St. Barnabas' Hospital, Portland, Me., from septicemia, October 13, 1913, aged 39 years. Dr. Downs was a Fellow of the American Medical Association and the National Antituberculosis Society. He was instrumental in the establishment of the Chase Sanatorium, Fairfield, Me.

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Medicine and Surgery

The Medical Journal Company

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Number One

JANUARY, 1913

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# *Editorial Comment.*

## THE SALVARSAN SITUATION.

*Memphis Medical Monthly.*

IT has been a matter of great interest to observe critically the trend of sentiment and opinion in this country and Europe with reference to salvarsan. There is no doubt whatever but that the early enthusiasm which attended the first introduction of the drug is waning greatly. That the use of the drug with demonstrable lesions of syphilis is attended with marvelous results has been demonstrated again and again. But, though the use of the drug is in its infancy, it has been amply demonstrated that its use will not thoroughly and finally eradicate the disease. It will be remembered that this was the earlier claim for the drug. The so-called *sterilisatio magna* which was the early claim for a single dose of the drug has been found to be a delusion and a snare. Its strongest advocates now recommend and employ several doses and then advise the use of mercury in some form. In the early burst of enthusiasm this old wheel horse of treatment was completely lost sight of, but now that the shortcomings of its newer confrere are being rapidly realized, it is coming into its own again.

A relatively large number of deaths have been reported and there are doubtless many that have not been put on record. The unfortunate feature of this phase of the question is that as yet we are absolutely and totally unfamiliar and unacquainted with

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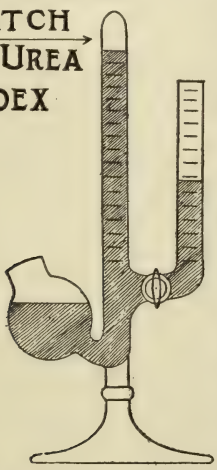

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the real causes which go to bring about these untoward results when they do occur. True enough that Ehrlich attributed the early fatalities to the use of salvarsan in cases not suited for its administration, such, for instance, as diseases of the nervous or cardio-vascular systems. But the surprisingly large number of deaths which have been reported occurring in young and seemingly robust individuals, having been found free from all traces of these conditions, has served to bring the drug into considerable disrepute. There has not been found any logical explanation for many of the fatalities. Again, it has been charged that some of the fatalities have been caused by bacteria in the distilled water used in the preparation of the drug. Whether or not this is a valid arraignment, we cannot say; but true it is that deaths have occurred in which the water was distilled and sterilized on the spot by men of proven competence.

As has been pointed out, this change of base on the part of the advocates of the drug is not conducive to increase in the esteem in which it is likely to be held by the profession. What is most important of all is this, that sufficient time has not elapsed for the final end results in the cardio-vascular and nervous systems to be noted. What these results will be we cannot tell.

After a careful review of the field, we may summarize the situation as follows:

1. Salvarsan is not a specific in the cure of syphilis.
2. It will work magic with open lesions.
3. Its use is not devoid of dangers; dangers that we now know positively of and those possible future dangers yet to be demonstrated.
4. It is believed that it is due to fairness and candor that the dangers and uncertainties of the treatment shall be fully pointed out to patients, and to a certain reasonable extent at least their decision and best judgment shall govern the plan of treatment.
5. The greatest advantage which salvarsan has over mercury is rapidity of action.
6. The ultimate place of salvarsan will probably be in the treatment of those cases of syphilis which do not yield readily to mercury. In the meantime accumulated experience has demonstrated that the mercury treatment had best be first employed.
7. The causative factor of bacteria in the water is almost positively a myth. Large quantities of salt solutions are used daily in hospitals frequently under circumstances of the greatest haste and untoward symptoms are not noted.
8. Salvarsan should be administered only by those expert in its use. The interior of a vein is a place that the competent surgeon has a great deal of respect for, and he is not going to enter it except for very good cause and under the most favorable circumstances.
9. This is a resume of the literature. Our pages are open to any one with extended experience who will further discuss the question.

---

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from epilepsy, petit or grand mal, and it has proven a *bete noir* to both ancient and modern medicine, first from its incurability, and second, from the almost inevitable resultant insanity of most violent and destructive type. Dr. Ralph H. Spangler, chief of the Medical Clinic of the Methodist Episcopal Hospital of Philadelphia, claims to have discovered a cure for it in *crotalin,* he having given more than 2000 injections of rattlesnake poison to more than 100 epileptics, with, as he says, most gratifying results.

He claims to have cured children with convulsions of a few months standing, as well as older persons who had been so terribly afflicted for as long as 20 years. The rattlesnake poison as a therapeutic agent—crotalin is obtained from the serpent by making him strike into a rubber bag, or by holding its head securely and having an assistant withdraw it from the gland with a hypodermic needle, which, when dried by evaporation between plates of glass in the sun, appears as yellow, scaly crystals. These are dissolved in glycerine and sterilized water, and used in one-hundredth grain doses or less, hypodermatically, at intervals determined by the repetition of the spasms.

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Further developments and clinical results will be required to establish and confirm these claims; and if such be obtainable, a most dread malady will be robbed of its terror, "Craig Colonies," and special institutions for epileptics rendered useless, and the number of inmates of our hospitals for the insane very materially diminished.

## DUST AND INFANTILE PARALYSIS.

*The Medical Council.*

We have been following up, in the California newspapers, the serious epidemic of this disease beginning in Los Angeles on June 15, and rapidly spreading over Southern California. By the middle of August 211 cases were reported in Los Angeles alone, several being adults. The Southern California Public Health Association is making a serious study of the disease, and the tendency is to lay stress upon the dissemination of the disease by dust and flies. There is a great cleaning up and street sprinkling

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crusade in progress out on that coast. This is the season when dust is greatly in evidence in that section, and we are especially anxious to know what conclusions are reached with reference to the question.

Incidentally it may be said that a committee which investigated the matter in Massachusetts reported as follows: "The greatest prevalence of the disease is during the season when there is the most dust. The distribution of cases in several towns on the more dusty streets and the cessation of several epidemics after the streets were well sprinkled have spoken for themselves."

The fall of the year is a great time for dust, and we urge our readers who may discover cases of infantile paralysis in their communities to start an immediate agitation looking to the elimination of street dust.

Dr. G. P. Gehring of Los Angeles writes us, in referring to the epidemic of the disease in that city, that the newspapers are needlessly alarming the citizens and are printing everything about the cases under flaring headlines. Also he contends that the municipality is largely responsible for conditions by allowing an indiscriminate opening of the streets during the dry season for the laying of gas, water and sewer pipes, and for street paving. He contends that there is a probability that the germ flourishes under similar conditions to that of the tetanus germ, and states that the intolerable dust on certain Los Angeles streets covers everything, gets into the houses, and contaminates foods exposed to it. The fact that it is natural for children to play in the dirt aggravates conditions.

## SYMPTOMS BRED BY THE MEDICAL EXAMINATION.

*Massachusetts Medical Journal.*

BERNHEIM in France and Buttersack in Germany have recently been emphasizing anew the suggestion of symptoms to the patient by incautious methods in the examination. This is a fact which all physicians know, but tend to forget. It is pointed out that the similarity in the symptoms in some clinics is probably greatly influenced by the powers of suggestion. Modern teachers of medical students are striving to impress upon these younger minds the far greater value of a statement which the patient made voluntarily or in answer to an indirect question as compared to that in response to a direct question. Here the medical mind has call for qualities almost legal in character; in fact, some say that a legal turn of mind is of great value especially in diagnosis. Dr. Reginald H. Fitz, one of America's greatest diagnosticians, graduated from Harvard Law School before studying medicine.

In examining the abdomen, as for appendicitis, Bernheim first has the patient palpate himself and locate the point of maximum tenderness. Then when he palpates he always commences at a distance from this area. (This is indicated also for other reasons, as for facilitating the examination, etc.) He makes a point of distracting the patient's attention from the special part under examination by questions as regards urination, vision, pains in neighboring joints, etc. Bernheim suggests that disturbances of coordination can often be best tested by asking the patient to jump and perform certain movements as though the effect on the heart were to be tested. Buttersack urges care in cardiac auscultation in acute articular rheumatism, often ausculting from the back as

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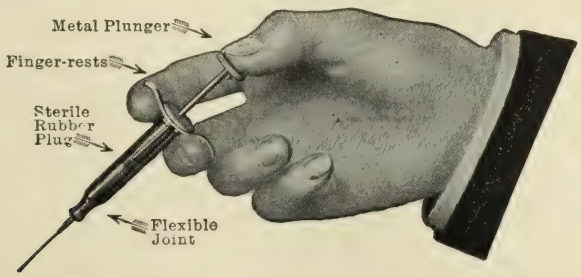


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though the lungs were being tested, and distracting the patient's attention in various ways.

We feel that we are merely emphasizing principles already well known. Every physician must, and generally does, work out his own salvation in adopting ways of bringing out a clear history with as little as possible use of the leading question, and in making his physical examination more productive and less harmful by distracting the patient's attention. These are all parts of the highest medical skill.

## ANTI-TYPHOID VACCINATION.

*Journal of Medicine and Surgery.*

ANTI-TYPHOID inoculation is now recognized by the profession as a safe and sane way to prevent, or at least mitigate, an attack of typhoid, and doubtless would be required by municipal authorities were it not for the fact that the public is notably slow to adopt anything suggested by the profession, because there is an inherent belief that any such recommendation is given with selfish motives. Improved sanitation is gradually wiping out typhoid anyway, and so by the time the public is educated to the point of adopting compulsory typhoid inoculation the disease in cities will be practically nil and so vaccination hardly necessary. However, it has come to stay and will be used in the armies throughout the world, in times of great typhoid epidemics, and by those whose business exposes them to typhoid.

The scientists who have worked out this deserve great credit, almost as much as Jenner himself. The latter was the pioneer of vaccination, and nothing can detract from the great service he has rendered humanity, but these modern scientists are likewise pioneers in preventive medicine, and it is our humble opinion that our descendants will have them to thank for paving the way to the preventive and prophylactic medicine of the future when diphtheria, measles, scarlet fever, whooping-cough, etc., will each and all be held in subjection by a small tube of clear solution—a serum.

We are hardly in accord with those who think all serums, whether prophylactic or therapeutic, the best treatment the profession can offer, but we do recognize some as wonderful and all as good, inasmuch as they are forerunners of the better ones to come.

## TREATMENT OF GONORRHEA IN GIRLS.

FROM experience with 300 cases, the authors conclude that for patients in whom the speculum can be used semi-weekly treatments once with 25 per cent. silver nitrate applied to the cervix and 10 per cent. to the vagina, followed by an application of petrolatum, and once by a 25 per cent. paste of iodoform in glycerine, give the best results. This treatment is not improved by the simultaneous use of gonococcus vaccine.

For little girls and virgins with an innocent infection, local cleanliness and the use of gonococcus vaccine give the best results. Because of the tendency to recurrence of the infection, however, this is not entirely satisfactory. In all cases with joint complications, vaccine is of great value.—*L. Morrow and O. Bridgman in Monthly Clycopedia and Medical Bulletin.*

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can be disinfected and deodorized by placing in a tub half filled with boiling water to which has been added a little "Platt's Chlorides." The tub should then be closely covered for two hours and the clothes thoroughly rinsed before washing.

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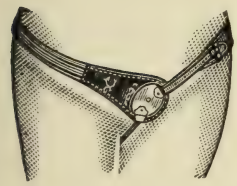

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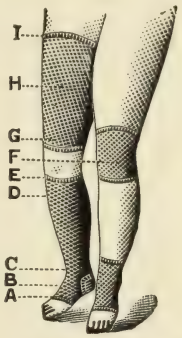


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| American Academy of Medicine | Charles McIntire, 52 N. 4th St., Easton, Pa. | |
| " Acad. of Ophthal. and Oto-Laryngology | Geo. F. Suker, M.D., 103 State St., Chicago, Ill. | |
| " Anatomists, Association of | G. Carl Huber, Ann Arbor, Mich. | December, 1912 |
| " Assn. of Genit. Urinary Surgeons | E. L. Keyes, Jr., 109 E. 34th St., New York | |
| " Assn. of Medical Examiners | G. Strohbach, M.D., Miami Bldg. Cincinnati, O. | Minneapolis, June 2-3, '13 |
| " Assn. of Military Surgeons of the U. S. | Charles Lynch, Washington, D. C. | |
| " Assn. of Path. and Bacteriologists | H. C. Ernst, Harvard Medical School, Boston | |
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| " Assn. of Obstetricians and Gyn | Wm. W. Potter, 238 Delaware Ave., Buffalo | |
| " Assn. of Orficial Surgeons | T. E. Costain, M.D., 100 State St., Chicago, Ill. | |
| " Assn. of American Physicians | G. M. Kober, 1819 Q St. N. W., Washington, D. C. | |
| " Climatological Society | Guy Hinsdale, Hot Springs, Va. | |
| " Dermatological Association | James M. F. Winfield, Brooklyn, New York | |
| " Electro-Therapeutic Association | J. W. Travell, 27 E. 11th St., New York | |
| " Gastro-Enterological Association | Chas. D. Aaron, 32 W. Adams Ave. Detroit, Mich. | |
| " Gynecological Society | Le Roy Brown, 70 W. 82d St., New York | |
| " Laryn., Rhin. and Otol. Society | Thos. J. Harris, 147 E. 40th St., New York | |
| " Laryngological Association | J. E. Newcomb, 118 N. 69th St., New York | |
| " Medical Association | G. H. Simmons, 103 Dearborn Ave., Chicago | |
| " Medical Editors' Associatiou | J. MacDonald, Jr., M.D., New York, N. Y. | |
| " Medico-Psychological Association | Charles G. Wagner, Binghamton, N. Y. | |
| " Medical Colleges, Association of | F. C. Zapffe, 1764 Lexington St., Chicago, Ill. | |
| " Neurological Association | Alfred R. Allen, Philadelphia, Pa | |
| " Ophthalmological Association | W. M. Sweet, 1205 Spruce St., Philadelphia | |
| " Orthoedic Association | Robert B. Osgood, 372 Marlborough St., Boston | |
| " Otological Society | F. L. Jack, 215 Beacon St., Boston, Mass. | |
| " Pediatric Society | Samuel S. Adams, 1 Dupont Circle, Wash., D. C. | |
| " Physio-Therapeutic Association | Otto Juettuer, M.D., 8 W. 9th St., Cincinnati, O. | |
| " Physicians, Association of | Geo. M. Kober, 1819 Q St., Washington, D. C. | |
| " Proctologic Society | L. H. Adler, Jr., 1610 Arch St., Phila., Pa. | |
| " Public Health Association | William C. Woodward, Washington, D. C. | |
| " Roentgen Ray Society | Percy Brown, 155 Newberry St., Boston, Mass. | |
| " Surgical Association | Robt. G. Le Conte, 1536 Locust St., Philadelphia | Montreal, 1912 |
| " Therapeutic Society | Noble P. Barnes, Washington, D. C. | |
| " Urological Association | Hugh Cabot, 1 Marlborough St., Boston | |
| Assn. Med. Officers A. and N. of Confederacy | A. A. Lyon, M.D., Nashville, Tenn | |
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| British Medical Association | Guy Ellison, London, England | |
| Con. of State and Prov. Bds. of N. A. | H. M. Bracken, St. Paul, Minn. | |
| International Congress on Tuberculosis | J. S. Fulton, M.D., Colorado Bldg., Wash., D. C. | |
| Mississippi Valley Medical Association | H. E. Tuley, 111 W. Kentucky, Louisville, Ky. | |
| Missouri Valley, Medical Society of the | Chas. Wood Fassett, St. Joseph, Mo. | |
| Nat. Con. State Med. Exam. and Lic. Boards | A. W. Suiter, Herkimer, N. Y. | |
| Nat. Assn. for Prevention of Tuberculosis | Dr. H. B. Jacobs, 11 W. Mt. Vernon Pl., Balto. Md. | |
| Pan-American Congress, Fifth | Dr. Ramon Guiteras | |
| Seaboard Medical Assn. of Va. and N. C. | John R. Bagby, Md., Newport News, Va. | |
| Southern Medical College Association | L. C. Morris, M.D., Birmingham, Ala. | |
| Southern Surgical and Gynecological Assn. | W. D. Haggard, Nashville Tenn. | Atlanta, Ga., 1913 |
| Southern Medical Association | Oscar Dowling, Shreveport, La. | Jacksonville, Nov 12-14, '12 |
| Tri-Medical Soc. of Md., W. Va. and W. Pa. | Percival Lantz, Alaska. W. Va. | |
| Tri-Medical Soc. of N. C., S. C. and Va. | J. Howell Way, M.D., Waynesville, N. C. | |
| Tri-State Med. Assn. of Miss., Ark. and Tenn. | R. McKinney, Memphis, Tenn. | |
| Tri-State Med. Soc. of Iowa, Ill. and Mo. | Jos. E. Chambers, M.D., 918 Pine St., St. Louis, Mo | |
| Western Surgical and Gynecological Assn. | A. T. Mann, M.D. Minneapolis Minn. | Cincinnati, 1912 |

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DR Joseph Brandaleone, Assistant Surgeon to the Post-Graduate Hospital, in a paper entitled "A New Treatment For Tuberculosis" *(Denver Medical Times, May 1912)* draws the following conclusions concerning the results obtained with Dioradin:

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Dr. H. F. Boatman, formerly of the Staff of the Independence Hospital, Iowa, (in an article to the *Southern California Practioner April 1912)* concludes the report of a very interesting case:

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The *Lancet-Clinic (Cincinnati) for Sept. 28, 1912*, prints a most interesting report of "21 Cases of Tuberculosis Treated by Dioradin," by Drs. M. J. Schwerd and A. L. Goldwater of St. Joseph's Hospital for Consumptives (New York.) The results obtained still further establish the efficacy of the remedy.

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as in my private practice, and in the clinic of the university, and am, perhaps, fairly well qualified to pass judgment."

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EVERY physician who has any considerable obstetrical practice owes it to himself and to his patients to familiarize himself with the oxytocic function of Pituitrin. Here is an agent which, according to reports in the medical journals of the Old World (notably of Germany)—if obstetricians adopt it generally, as now seems likely—is destined to rob childbirth of much of its pain and terror. What shall we say of such an agent that fails but once in over a hundred cases in which it is used? And that is just what happened in Dresden, according to a report of Vogt of the Royal Gynecological Clinic of that city. Vogt adds: "It was not necessary to have recourse to forceps in a single instance in which Pituitrin was employed."

For the benefit of physicians who are uninformed on the subject, it may be said that Pituitrin is an extract of the posterior or infundibular portion of the pituitary gland. While in use for a number of years—chiefly, perhaps, as a hemostatic and heart stimulant—it is only of late, comparatively speaking, that its value in uterine inertia has been fully understood. The product is prepared and marketed by Parke, Davis & Co., to whom inquiries should be addressed for further particulars of this remarkable agent. Not very long ago the company issued a pamphlet in which a number of interesting and surprising case reports were published. We understand that copies of this Pituitrin pamphlet are still available and may be obtained upon application to Parke, Davis & Co. at their general offices in Detroit, Mich.

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Acting on the heart in this definite way, if used as a routine stimulant, coffee, in time, must inevitably produce more or less irregularity of the heart's action, and thus be the forerunner of greater or less serious chronic trouble (some persons being more susceptible than others.)

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# Abstract.

## THE PRACTICAL IMPORT OF RECENT WORK ON HYSTERIA.

*By Tom A. Williams, M.B., C.M., Edin., Washington, D. C.*
Member Corresp. Socs. of Neurol. and Psychol. of Paris.

A HYSTERIAL symptom is merely one produced by suggestion. Hence the disorder is a purely psychogenetic one. The stigmata, however, do not occur in the absence of medical examinations or other sources of suggestion. This is readily observed in simple cases, which are frequent, and may be ascertained by a profound analysis in nearly all. Trophic symptoms and hyperthermia are products of somatic disorder, such as hyperthyroidism or latent infection, or they may be the artefacts of malingerers; and in neither case are they hysterical. Nor is emotivity hysteria.

The genetic idea, from which springs the hysterical symptoms, must be sought in order to make therapeusis satisfactory. Any success of mere suggestive therapy is only temporary, and rather favors relapses by increasing proneness to further suggestions of all kinds. Rational enlightenment of the patient into the mechanism of his symptoms is the key to success. Isolation as a means to this end is rarely required. Physical measures are a disadvantage unless specially indicated, as they divert attention from the real aim, which is psychotherapy. This should inculcate principles rather than details. But the minutiæ of a psychomotor discipline need to be carefully shown to the patient and attendant. Cases illustrate these points. See also *Medical Annals,* January, 1912.

# Editorial Comment.

## FOR AND AGAINST DR. WILEY.

*Bulletin of Pharmacy.*

FINALLY, we may say that one of the most important actions taken by the N. A. R. D. executive committee last month was its adoption of a series of resolutions urging President-elect Wilson not to appoint Dr. H. W. Wiley secretary of the Department of Agriculture. In the recent three-cornered presidential campaign, Dr. Wiley turned his back upon both Roosevelt and Taft, under whom he had respectively served, and openly supported Wilson, speaking in his behalf at a number of meetings. This gave rise to the rumor that he would be given the agricultural portfolio.

Fearing that there might be some truth in the rumor, the N. A. R. D. executive committee declared in its resolutions that Dr. Wiley was unfitted for the place; first, because he was not a practical agriculturist, and secondly, because his former conduct of the Bureau of Chemistry was "characterized by arbitrary action detrimental to legitimate drug and other classes of beneficial business." The resolutions point out that Dr. Wiley, when chief of the Bureau of Chemistry, was restrained in a measure by officers of the Government having co-ordinate and superior rank, who exercised a steadying and restraining influence, while as secretary of the Department of Agriculture he would be a law unto him-

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self, and that his appointment would be "fraught with danger, subversive of justice and progress among our people, and inconsistent with the careful, sane, deliberative and just administration of important executive functions."

On the very day that we read these resolutions in N. A. R. D. Notes, where they were "featured" in black type, we received a letter from Albert Schneider, editor of the *Pacific Pharmacist* in San Francisco, enumerating reasons why Dr. Wiley should be made Secretary of Agriculture. Dr. Schneider's letter was a circular communication addressed to the editors of all the pharmaceutical journals, and it contained the statement that Dr. Wiley was "the best qualified man in the United States to direct the work of the department." Dr. Schneider said that "Dr. Wiley no doubt had made mistakes, but the great good that he has done, and that he is capable of doing, will most certainly outweigh any harm that may have resulted from his mistakes."

So it is quite evident that there is going to be a difference of opinion about the appointment of Dr. Wiley to the agricultural portfolio. In the meantime, no one knows the mind of President-elect Wilson, and he will probably keep everybody guessing.

## DR. WILEY'S SUCCESSOR APPOINTED.

*Bulletin of Pharmacy.*

MEANWHILE, readers of the newspapers are doubtless aware of the fact that a successor to Dr. H. W. Wiley, as chief of the Bureau of Chemistry, has finally been appointed. The lucky or unlucky man is Dr. Carl A. Alsberg. Dr. Alsberg has previously had no experience whatever in the work of the Bureau of Chemistry, or in the enforcement of the food and drugs act. His position has been that of biochemist in the Bureau of Plant Industry. His work, however, has greatly commended itself to Secretary Wilson, and it has been known for some time that the Secretary favored his appointment. President Taft did not finally take action until last month. The work of the Bureau of Chemistry covers an enormous amount of purely chemical endeavor, but in the public mind the bureau is chiefly associated with the enforcement of the food and drugs act. All of the public discussion about candidates for the place has revolved around this topic. Dr. Alsberg comes to the place uncommitted to any particular policy with regard to food and drug matters, and no one seems to know at present whether he will be a radical of the Wiley type, or a conservative of the Wilson type. The fact, however, that Secretary Wilson strongly favored his appointment indicates that we shall have from Dr. Alsberg a sane and just, but nevertheless honest and vigorous enforcement of the law.

## CAN THE INFANT DIGEST STARCH?

*Medical Summary.*

WE have before us an excerpt from an article in the October number of *Pediatrics*, written by its editor, Dr. Fitch. The article is entitled "Modified Cow's Milk as a Substitute Food in Infant Feeding," and the author gives the benefit of personal research work along this line of endeavor. The paper shows originality and does not patter down the line of conventionality as most of the stuff written on infant feeding does.

For example, the author knocks the old time-honored belief

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that a baby cannot digest starch in this manner: "Theoretically, the child under six months, because of the deficiency of salivary and pancreatic secretions is said to be incapable of digesting starches. Practically, this is not true. Nearly every fluid in the human economy has a diastatic ferment, and as a matter of fact the very young infant does digest starch. We have seen too many babies successfully fed on arrow root to deny this fact."

Again Dr. Fitch says: "The addition of cereals to cow's milk is not only allowable, but is to be most warmly recommended, not only in older children, but also very young infants. The advantages of cereal modification, in addition to the readier digestion and gain in weight, are to be found in the finer subdivision of the casein in the stomach, in the emulsification of the fat, in the disappearance of soapy and dyspeptic stools, in the proteid-sparing power afforded by the cereals, and, finally, in the general increment of growth.

"This is the experience of the leading pediatrists of the world. Not every infant by any means can take cow's milk, or ass' milk, or goat's milk, but that starch foods may be added with benefit to cow's milk in the majority of cases is established beyond all question, experimentally, chemically and clinically."

## RICHMOND MEDICAL SCHOOLS TO BE CONSOLIDATED.

*Virginia Medical Semi-Monthly.*

THE long agitated question of the consolidation of the Medical College of Virginia and the University College of Medicine, both located in Richmond, seems at last about to be definitely settled. Committees representing the two schools have had several meetings, and, on good authority, satisfactory arrangements seem about to be perfected for their amalgamation, though each will retain its individuality until the close of the present session.

The combined college will be known as the Medical College of Virginia, owing to the State ownership of the latter institution. Though there are many surmises as to who will be president, it seems that this is a matter yet to be finally decided.

Both colleges have taken a high stand in the Association of American Medical Colleges, and this consolidation, which will offer medical students in Richmond exceptionally fine clinical and laboratory advantages, will of necessity serve to make the united schools stronger and more influential, and thus make Richmond one of the leading medical centers of the country.

## SUGAR AS A "PICK-ME-UP."

*By Woods Hutchinson, M.D.*

*Pacific Medical Journal.*

SUGAR is a real food of very high value, and is very promptly and readily absorbable. A violent craving for sugar, leading to excess, largely disappears in children when their healthy demand for it is supplied by a proper mixture with their foods, while no child yet has ever been born with a taste for alcohol, pickles, tea, coffee or tobacco.

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food which will restore working power to fatigued muscles of both men and animals so quickly and effectively as pure sugar. Indeed, it was suggested by Professor Lee that tired business men, carried beyond their regular lunch hour, would find a few lumps of pure sugar one of the best of temporary restoratives and "pick-me-ups," far superior to alcohol.

The rôle and importance of sugar as a rapid reliever of fatigue is one which we are only just beginning to appreciate, and which goes surprisingly far already. It has been incorporated into the most hard-headed, cold-blooded, matter-of-fact diet on earth, the German army ration, especially the "forced march" emergency ration. No other food of its bulk can take its place.

It is the belief of careful observers of men, particularly in the tropics, that the larger the amount of sugar and sugar-containing foods they are supplied with, the less alcohol and other stimulants they will crave. For instance, the United States Government now buys the best and purest of candy by the ton and ships it to the Philippines, to be supplied to the canteens and messes, finding that it diminishes the craving for native brandy; and it has long been a matter of comment from thoughtful observers that the amount of drunkenness of a race or class is in inverse ratio to the amount of sugar it consumes.

## THE RECTUM IN CONSTIPATION.

*Medical Summary.*

As a rule, cathartics and laxatives are given with a view to stimulating the colon and small intestines when the rectum may be regarded as the main offender. A full rectum is disposed to soon become obtunded in sensibility and its muscular fibers easily acquire a state of atonicity. A narrowed or constricted rectum, due often to obscure conditions, is exceedingly common. The healing of fissures and pile tumors is especially liable to cause cicatricial tissue at the distal extremity with consequent narrowing of the canal's lumen. We have experienced excellent results in cases of obstinate constipation by means of rectal dilatation. This may be accomplished instrumentally under an anesthetic in severe cases. Milder cases are helped by digital dilatation, after which the patient may administer daily self-treatment with a set of dilators made of glass or hard rubber.

# *Excerpts.*

## TREATMENT OF AMEBIC DYSENTERY.

The author describes a new method of treating amebic dysentery and hepatitis, consisting of hypodermic injections of soluble salts of the alkaloid emetine. Vedder shows that this substance, the principal alkaloid of ipecacuanha, has the power in high dilutions of destroying amebae in broth cultures; the author confirms this by testing the effect of emetine hydrochloride on *Entameba histolytica* in dysenteric stools. When mucus containing numerous active amebae was placed in the alkaloidal solution, the pathogenic organism was immediately killed and materially altered in its microscopic appearances by a 1-10000 solution, while after

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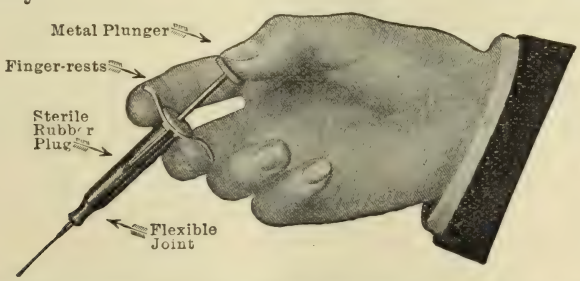


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a few minutes they were rendered inactive and apparently killed by as weak a solution as 1-100,000. Administration of emetine hydrochloride hypodermically in a few cases of amebic dysentery yielded excellent results. It did not produce vomiting, even though in the same cases ipecacuanha given by mouth had done so; the alkaloidal salt was at first given in doses of 1/6 grain (0.01 Gm.), this being equal to 15 grains (1 Gm.) of ipecacuanha. In the latter cases 1/3 grain (0.02 Gm.) and even 1/2 grain (0.03 Gm.) were given without producing any ill effects on the patient, though their action on the disease was magical. The hydrobromide of emetine might also be given, but it is not quite so soluble as the hydrochloride. An advantage of the method is that the drug can be given even when the administration of ipecacuanha by the mouth is impracticable.—*Leonard Rogers* (*British Medical Journal, June 22, 1912.*)

## GENESIS OF CRAMP OF WRITERS AND TELEGRAPHERS.

True occupational cramp, in the author's opinion, is genetically psychological. Analysis of many cases shows it to be dependent upon the pre-emption of the muscles by a tic, which prevents the proper performance of the professional act. The tic is, of course, psychogenetic, and it is the cause of this that must be attacked if treatment is to be successful. The patient's belief in physical causation may be hard to remove; these cases must therefore be frequently seen. The measures used are: (1) Psychic readjustment, so that the patient may understand what he is trying to do. Time may be required to achieve this. (2) Psycho-motor discipline in the form of exercises graded by the physician. The temporary physical disabilities from which the notion of incapacity may in the first place have arisen are of minor importance. Psychological reconstruction is the keynote to the treatment.—*T. A. Williams* (*Monthly Cyclopedia and Medical Bulletin.*)

## SCARLET FEVER, DIAZO REACTION IN.

*Monthly Cyclopedia and Medical Bulletin.*

The diazo reaction was studied by the authors in 375 cases of scarlet fever, 56 of diphtheria and 37 of serum sickness with various types of rashes. A positive result was obtained in the first week of the disease in 17.3 per cent. of scarlet fever and 12.9 per cent. of diphtheria patients. It is during this week that scarlatiniform serum rashes are apt to develop and make a differential diagnosis from scarlet fever quite difficult. The percentage of positive diazo reactions in serum sickness was found to be much lower. A few positive reactions were observed, averaging 10.8 per cent. for all kinds of rashes, but many of these results may have been due to diphtheria. The value of the diazo reaction in differential diagnosis, on the whole, proved slight, as the percentage of positive reactions in scarlet fever and diphtheria is already low. In measles, however, in which the reaction is positive in 75 per cent. of cases, a negative reaction in a case presenting a morbilliform rash would be of value in differential diagnosis.—*S. S. Woody and J. A. Kolmer* (*Archives of Pediatrics, January,* 1912).

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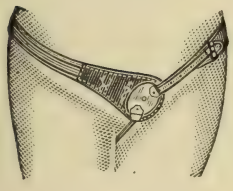

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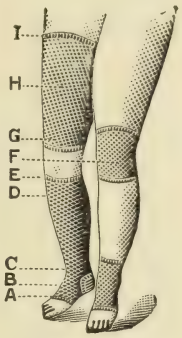


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The center of the window was occupied by tuberculin and the card setting forth the character of the exhibit. Pyramids of antitoxin rose at both sides in the rear of the window, the serums being similarly placed. The vaccines were distributed among the other specimens in symmetrical array, while the bacterins were made part of the front section. There were also two cases divided into three sections, the middle one containing tuberculins, with rabies vaccines at the bottom; the one at the right-hand side diphtheria antitoxin, and the one on the left bacterial vaccines. Displayed with the bottles were the syringes used in administering the doses.

The exhibit embraced all of the products turned out by the H. K. Mulford Company, the list being made up of all the bacterins, the antitoxins, concentrated or globulin; anti-dysenteric serum, anti-meningitis serum, anti-pneumococcic serum, anti-streptococcic serum, normal serum, smallpox virus, the tuberculin dilutions and the diagnostic reagents. The card suspended by wires in the center of the window set forth that "We keep our stock in a special biological refrigerator, to be seen inside."

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We shall be pleased to have expressions of experience from the profession.

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I AM undertaking an exhaustive research into the pathology, etiology and dieto-therapy of diabetes mellitus. I am very anxious to hear from every physician in the United States who has a case under treatment or who has had any experience in the treatment of this malady. Von Noordam says "the best treatment for the diabetic is the *food* containing the *greatest* amount of *starch* which the patient can bear without harm." If any physician who reads this has similar experience or contrary, and would take the trouble to write me, I would esteem it a special privilege to hear from him, if only a postal card. Kindly address

WILLIAM E. FITCH, M.D.,
355 West 145th street, New York city.

# Abstract.

## THE PSYCHIC EFFECTS OF ACCIDENTS.

*By Tom A. Williams, M.B., C.M., Edin., Washington, D. C.*

THE actual emotion from an accident may stimulate internal secretions in an injurious way by a mechanism discussed in the paper. But the effects are only temporary unless maintained by morbid ideas gained from others after the accident, or previously present in the mind of the injured. Prepossession leads to abotraction with diminished capacity of thought. This creates a vicious circle. The dissipation of the false idea of a body disease is interfered with by the patient's unconsciously exaggerating symptoms in order to justify what he is beginning to doubt. The passage into deliberate deception is then easy.

It is, of course, not the trauma which is psychopathogenic; the real cause is the ideationally determined complex in the patient's mind. It is a suggestion, and can be just as effective apart from an accident at all. Illustrations are given.

Nor is litigation itself the cause of sinistrosis. It is merely a powerful suggestive determinant. Thus, in a patient in whom haematomyelia had greatly impaired the efficiency of the right hand, and who believed himself unable to work as a mechanic because of somnolence, unsteady gait, partial urinary incontinence and impotence, the author detected the psychogenic character of much save the muscular atrophy and restored the patient without question of indemnity.

Thus, treatment depends upon rational knowledge of genesis, which leads to proper re-education of the patient's viewpoint. Mere assurance and encouragement only antagonizes the patient. The main aim is the removal of false notions—suggestions; and this is most durably done by rational enlightenment into a true perspective. It is the treatment of hysteria. The article is closed by an illustrative case.—*Month. Cyclo., November,* 1912.

# Editorial Comment.

## THE BATTLE OF THE COLLEGES.

*The Medical Standard.*

WITHIN the last seven years the number of medical colleges in the United States has fallen from 251 to 116 or 118. Changes are so rapid nowadays that it is almost impossible to keep accurate

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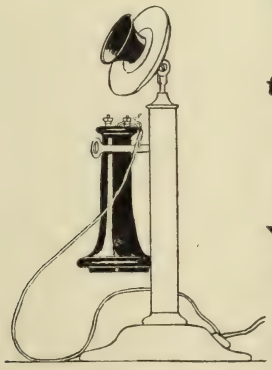

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count. This shrinkage in numbers is due to several factors, but the most important one is the constant increase in the requirements of the different State examining boards, these, in turn, being the result of the agitation for higher standards carried on by the Council on Medical Education of the American Medical Association. This council now divides the medical schools of the country into three classes. The "Class A" schools are few in number, since to qualify for this distinction they must have liberal endowments or generous State support. They are our scholastic plutocracy. The majority of medical colleges fall within "Class B," the members of which are only safely within the pale. But to belong to "Class C"—this is anathema! The graduates of institutions of this class are already, by that very fact, debarred from practicing their profession in a number of States—a number which is constantly increasing.

The importance of graduating from a school that stands well with the State boards is already well understood by the medical students themselves. This was strongly demonstrated by a recent experience in Milwaukee. The medical department of Marquette University of that city was recently reduced from Class B to Class C, or at least it was announced that such a reduction in grade would take place on January 1. As soon as the news of this important change was made public the 300 students of this college demanded that the changes necessary for its retention in the higher class be made at once or they would go to another institution. It is said that they immediately made overtures to two Chicago colleges, and possibly to others, with a view to coming over in a solid body to some school which could give them the standing desired. At the present writing the outcome is not settled, but it is safe to say that if Marquette passes to Class C its student body will secede en masse.

The attitude of the students in Milwaukee will eventually be that of students in other cities just as soon as they realize that the colleges they are attending cannot give them diplomas which, from the standpoint of the State boards, can be rated at 100 per cent. It is this attitude of students and prospective students which will eventually kill off the cheap schools. After all, no matter how devoted the embryo physician may be to knowledge for its own sake, it is the diploma he wants, and if that diploma does not give him the legal right to become a practitioner anywhere in the country he feels that he has been defrauded—and, indeed, he has been.

Some of us idealists feel that our educational reformers are going a bit too fast. The classifications of medical schools at present depend very largely upon the amount of money these schools have to spend for buildings, equipments and salaries. In other words, money seems to count more than individual scholarship. The same money standard counts in getting the medical education; the boy whose purse is half empty is handicapped, and if his pockets are quite empty he has no chance at all. This is the tendency, we say. In truth, it is still possible for young men of courage and intelligence to get a medical education, and in all probability it always will be. The pity is that there should be any increase in the handicap, for these poor boys are the hope of the nation—also the hope of the medical profession.

But we shall not quarrel with the tendencies toward higher

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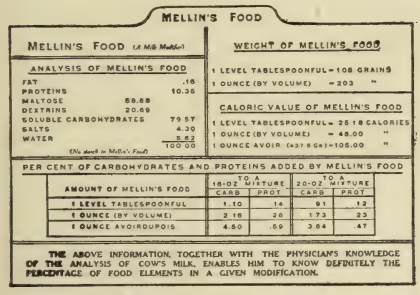

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standards in our profession. They are to be welcomed in the main, but watched carefully by those who are still imbued by faith in the democracy of science and who feel the necessity for essential equality of opportunity if our profession is to be recruited from those by nature best suited to succeed in it.

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## EDITORIAL PETULANCE AND PROPRIETARIES.

*The Medical Sentinel.*

THE *A. M. A. Journal* takes issue with the *Medical Standard,* and in a recent editorial becomes especially peeved and petulant over the following item in the *Standard:* "For every $1000 paid the doctor the people pay about $1500 for 'patents.' Instead of abusing the druggists or the people who make these more or less 'popular' medicines, it may be well enough to ask why the people prefer this stuff to our services. Possibly there is something wrong with *us.*"

It insists that the significance of the statement that the patent medicine business is increasing is due to the fact that, regardless of the dictum from the "powers that be," physicians are still prone to prescribe secret or semi-secret "ethical proprietaries." The exact connection between the effect and its cause is thus glibly explained (?): "The public is awakening to the fact that there is very little difference between the secret or semi-secret 'ethical proprietary' prescribed by the physician and the secret or semi-secret 'patent medicine' bought over the counter."

How illogical this assumption is must be apparent to every physician who claims that God-given gift that, in many of us, atrophies from non-use—the right to think for ourselves. Following this line of biased reasoning, why not extend it to other articles the physician prescribes? Cannot the public learn that the calomel we prescribe is the same thing they can purchase over the counter? When we prescribe cascara cannot the same thing be purchased from any druggist? How many drugs are there that we prescribe which cannot be bought at any drug store? And is our practice then declining and leaving us for the drug clerk because, forsooth, they have discovered that many of the drugs we prescribe can be bought over the same counter?

The fact is that there will always be a demand for patent medicines until human nature changes. The public is constantly on the lookout for the miraculous, and there will always be those who delight in diagnosing their own cases and prescribing for themselves. The glowing advertisements in reference to patent medicines, their very extravagance of statement, their touch of the mysterious, affects one portion of the public in much the same manner that a silk hat and a Van Dyke beard affects others.

This credulity, this lure of the miraculous, is inbred in most of us, and no editorial ebullition, no gall-dipped pen, can word a proclamation that can offset it. We are all aware how the very thought of a proprietary remedy excites the temper and rankles in the flesh of this otherwise excellent journal, yet, despite all advice, remonstrance and thunder from the gods this fact remains: many proprietary remedies have a value, an efficiency and appearance far above any similar extemporaneously prepared prescription, and there will continue to remain physicians who will pre-

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scribe these remedies whenever they feel they are indicated and will benefit their patient. If that be heresy, make the most of it!

The iconoclast of today is frequently the God of tomorrow, and in no other profession is there so much need of men who think for themselves.

We wish to confirm the diagnosis advanced by the *Medical Standard:* "Possibly there is something wrong with *us.*"

---

## WHAT IS PROGRESS?

*Long Island Medical Journal.*

"It would be happier for a race to be free and diseased rather than healthy and enslaved." We do not know who the author of these words was. We recently encountered them in a book by Berry Hart, the eminent gynecologist and teacher of Edinburgh. They excite thought.

There is an implication in the quotation that freedom entails disease and that health connotes slavery. If this were true, what hope would humanity have?

Because love is blind—and free—people marry with little or no thought concerning heredity. Were they to follow the rules of Galton, the great student of eugenics, perhaps the race would be better, considered from certain points of view, but certainly it would be less free. There are those who would institute legislation in respect to marriage—legislation along so-called scientific lines. In fact, the thing has been done here and there. We fancy that we can regulate affection and control natural selection, but Nature seems to take no defects into account in the carrying out of her biologic program. Our problem, the problem of a higher civilization, seems to be the thwarting of natural laws, with no penalties in the way of lessened freedom, unhappiness and balked progress. This is "some" problem. The eugenic program is supposed to make for a healthier race, yet, according to the thinker whom we have quoted, it will probably make for racial deterioration, in a sense, as well. Would this be progress? What is progress?

William Winter, the noted critic, in a recent speech before the Lotos Club, spoke of the vaunting of progress as a vain thing so long as our prisons are overcrowded and our State hospitals overflowing, and so long as discontented poverty is embattled against entrenched wealth, not to mention other counts. On the day following Winter's address the New York *Times* printed an article which purported to be the Church's view of progress. After recounting the facts indicating progress under the administration of a distinguished prelate about to be raised to very high office, the *Times* article stated that, "in addition, the number of reformatories, asylums and homes under his care have multiplied exceedingly."

The progress of William Winter is clearly not the progress of the *Times* nor that of the distinguished prelate. Winter cannot think of an advanced and free race as greatly diseased, while the *Times* and the prelate are seemingly content to accept an unhealthy society as a progressive society. There is much confusion here as everywhere in human thought and action. So we shall not attempt to define what progress is. We have no zeal for crystallizing and reducing to static order that which we would better think of after the manner of G. K. Chesterton. Such definitions must be left to

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## WAR AND PESTILENCE.

*The Medical Standard.*

So far as it is possible to learn from the meager reports from the scene of war in the East, not for a generation, and perhaps not for a century, has there been a struggle between hostile armies in which the combatants were so poorly prepared to care for their sick and wounded. The stories that filter back to us from Constantinople give a dreadful picture of the suffering of the wounded and sick. In none of the contending armies are there a sufficient number of surgeons or nurses, and this deficiency is particularly true of the Turkish force. One nurse, who has had previous experience in war, is reported as saying that the scenes she had been compelled to witness were heartrending, and that if the people of the civilized world could see and understand they would put an end to war.

As a further complication, and to make the condition more poignant with suffering, cholera has appeared among the Turkish troops, and probably also among the Bulgarians. The sick have been either neglected entirely or herded like sheep, and many of them have died absolutely unattended in the fields, by the roadside, in ditches—anyhere. There are thousands of cholera patients in and about Constantinople, and rumor says that hundreds of cholera patients have been taken to Sofia, the Bulgarian capital. In the spring the disease will undoubtedly be scattered from the Hellespont to the Adriatic and from the Black Sea to the Mediterranean. Unless Europe is vigilant it may spread to the North Sea.

Thus does history repeat itself. War and Pestilence, twin sons of barbarism, go hand in hand.

## AUTUMN DYSENTERY.

*The Medical Council.*

There is no form of dysentery with which the fall of the year has any specific or direct bearing, but a great many cases of dysentery occur in the fall, especially in a dry season. We have had a wet summer, and a dry fall is likely in consequence. When the streams get low, the water is apt to be much contaminated, especially so in the fall when there is so much decaying vegetation. The cases of dysentery occurring in the fall sometimes recover rather slowly, and they have certain features in common with amebic dysentery.

It is our experience that in addition to the usual medication for dysentery, a milk-free diet and local treatment is advantageous. Cold water injections (45° Fahr.) with glass irrigator and colon tube, and with patient in the knee-elbow position, are effective, especially if medicated with acetozone, alphozone, protargol, thymol or quinine bisulphate, the latter with care. Dr. Rose injects $CO_2$ into the rectum for the relief of tenesmus, and has had good results. In case of hemorrhage from dysenteric ulcers, high injections of Trémolière solution (2 per cent. calcium chlorid in 5 per cent. solution gelatin) gives excellent results.

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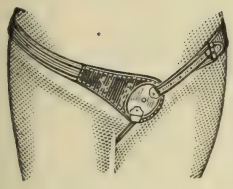

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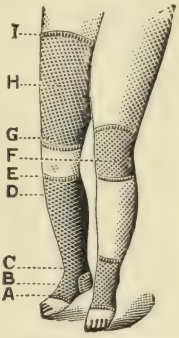


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Following the earlier announcement of the results of investigations by Weintraud and his collaborators (Municipal Hospital, Wiesbaden), since amplified and confirmed, Atophan has been the subject of extensive and thorough pharmacological and clinical study by Georgiewsky, University of Charkow, Russia; Deutsch, clinic of Prof. Friedrich von Mueller, Munich; Starkenstein, University of Prague; Richter, University of Berlin, and Plehn, Municipal Hospital "Am Urban," Berlin, and others. These authors, while differing in regard to the mechanism of the action of Atophan, unanimously agree as to its unparalleled ability to increase the uric acid excretion and its rapid beneficial influence upon the subjective and objective symptoms of gout, acute and chronic.

Weintraud's suggestion that Atophan should

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5—Tubercle bacilli decrease or disappear.
6—It is not irritating or dangerous, and is easy of administration.

The results of other investigators bear out Dr. Wells' conclusions:

IN a paper entitled "Treatment of Surgical Tuberculosis by Dioradin" read before the Section of Surgery of the Royal Academy of Medicine in Ireland by R. Atkinson Stoney, M.B., F.R.C.S.I., Visiting Surgeon to the Royal City of Dublin Hospital, the following statement is made:

"I do not wish for a moment to claim that this method of treatment has worked any miracles. I have from time to time seen instances of cure in practically every one of these manifestations of tubercular disease under other methods of treatment, though I must confess the cure has always taken a much longer time to be brought about. But taking the whole fifteen cases together, I think that the results are decidedly good, and they are certainly better than any I have ever obtained by the use of tuberculin in any of its many forms."—*Medical Press and Circular, March 27th 1912.*

DR Joseph Brandaleone, Assistant Surgeon to the Post-Graduate Hospital, in a paper entitled "A New Treatment For Tuberculosis" *(Denver Medical Times, May 1912)* draws the following conclusions concerning the results obtained with Dioradin:

"I would recommend this treatment for incipient stages, where I believe cures can be effected. In the second stage of the disease, cures may follow the treatment, but at least the disease can be arrested and the patient made more comfortable: in the last stage I have found that the treatment makes the patient more comfortable, and prolongs the life. It is worthy of consideration and trial in cases of tuberculosis that will respond at all to any medicinal treatment."

Dr. H. F. Boatman, formerly of the Staff of the Independence Hospital, Iowa, (in an article to the *Southern California Practioner April 1912)* concludes the report of a very interesting case:

"This is not a favorable case for any treatment, but the surprisingly happy results obtained by Dioradin lead me to conclude that in this remedy we have a most potent agent for destroying or inhibiting the growth of the tubercle bacillus."

The *Lancet-Clinic (Cincinnati) for Sept. 28, 1912,* prints a most interesting report of "21 Cases of Tuberculosis Treated by Dioradin," by Drs. M. J. Schwerd and A. L. Goldwater of St. Joseph's Hospital for Consumptives (New York.) The results obtained still further establish the efficacy of the remedy.

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prove valuable also in certain articular, cutaneous, aural, ocular and neuralgic manifestations of the disturbed uric acid metabolism, such as various forms of rheumatism, eczema, pruritus, otosclerosis, iritis, episcleritis, neuritis, sciatica, lumbago, hemicrania, etc., has been readily taken up by many American and foreign physicians and specialists, and from the reports so far received the action of the drug in these indications would seem to equal its already established superiority in gout. It is an important point, emphasized by all observers, that Atophan likewise possesses analgesic and antipyretic properties, which are considered by many to be equal, if not superior, to those of the salicylates.

A most interesting and valuable paper entitled "Atophan Therapy in Gout," was read by Dr. Retzlaff of the clinic of Professor Kraus, Charite, Berlin, before the Verein fuer Innere Medizin und Kinderheilkunde, Berlin, January 15, 1912 (*Deutsche Medizinische Wochenschrift*, February 29, 1912). The author reviews the investigations of the above-named observers and states, as a result of his own thorough pharmacological and clinical research, that in Atophan we unquestionably possess a drug which exercises so unprecedented an influence upon the nuclein metabolism and the mobilization of uric acid that it may be regarded as a specific in the treatment of gout. Like all the other investigators, the author lauds the prompt effect of Atophan upon the retrogression of the inflammatory and painful symptoms, as well as the rapid improvement in the general condition of the patients. Untoward gastric or renal by-effects were very rarely observed, and if they occurred, the writer found could be readily counteracted by the giving of small doses of alkalis. In acute gout, Retzlaff recommends the daily dose of 30 to 45 grains of Atophan for a period of four to five days, and as a prophylactic of attacks in chronic gout, the giving every two weeks of the same dose for three days.

The paper was discussed by Professors Klemperer, Fraenkel and Dr. Gudzent of the clinic of Professor His, whose own clinical and laboratory investigations concerning Atophan, having yielded in the main very favorable results, will be the subjects of early communications.

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### Cell Nutrition.

ALL classes of cells are made to live and perform their several functions by the phenomena of cell nutrition, and whenever malnutrition, intoxication or other causes impair the special function of cells they do so by producing some intrinsic metabolic defect. Agents which will directly or indirectly repair metabolic defects are true cell tonics. A very large experience and a close and careful clinical study of all pathological conditions show conclusively that Bovinine is an ideal cell tonic and food. It stimulates the cells to healthy proliferation. It tones the newly-born cell, giving it a full and normal power of absorbing, and immediately meets this demand by supplying a full and complete nutrition.

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### Convalescence from the Exanthemata.

THE first two or three months of the year are usually characterized, in the experience of the family physician, by the occurrence in his practice of a crop of cases of the contagious diseases of children, especially scarlet fever, measles, German measles, etc. This is accounted for by the readiness with which contagion is spread in the schools when ventilation of the schoolroom is the least perfect and the closer housing of school children during school hours favors the distribution of communicable

diseases. As the diseases in question are self-limited in nature, expectant and symptomatic treatment, together with precautions as to isolation, etc., is about all the physician is called upon direct. It is well known, however, that in all but the mildest cases the adolescent subject of scarlatina, or measles, is usually more or less debiliated or devitalized when convalesence is established. Special care should be taken to avoid the administration of any tonic or reconstituent which is likely to disturb the child's digestion, or, by inducing constipation, to minimize the appetite or desire for food.

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# Editorial Comment.

## THE PRESENT TREND OF MEDICAL JUDGMENT IN REGARD TO THE OPERATIVE TREATMENT OF EXOPHTHALMIC GOITRE.

*Interstate Medical Journal.*

We know little of the pathology of this disease. While most observers agree that the change in the thyroid gland is a part of the picture, nevertheless there is much confusion of testimony as to just what these changes are; and, furthermore, there are those who deny that a specific change in the thyroid tissue is an essential of the syndrome. With regard to the specific functional changes in the thyroid and in other structures, such as the brain, the hypophysis, the thymus, adrenals, lymphatic tissue, our knowledge is still more chaotic, or, better, our surmises.

On the clinical side of the question we are in a somewhat better established position, but even here there is some lack of agreement as to the details of the syndrome, and the answers to the therapeutic question have been most divergent.

On the one hand, a large element of the clinical picture is made up of symptoms that may be designated as nervous and which can be improved by proper hygienic and dietetic treatment, and it has been maintained by many that the improvement following surgical interference is either coincident or is the result of mental impression.

On the other hand, the rationale of the operation is based almost wholly upon a rather evident overactivity in the blood supply of the thyroid gland and the clinical results following operation. Until somewhat lately quite a large proportion of the medical profession has not been willing to accept the latter part of this evidence as conclusive.

Add to this the fact that, without the exercise of the best judgment and technical skill, the operative treatment is not free from a large mortality, and that successful surgical results are but in a small percentage of cases the restoration to full normal health, it can readily be understood why the medical profession, as a whole, has not accepted surgery in this disease as readily as it has in many other diseases where the indications and the results were less equivocal.

The most potent factor that has held many fair-minded and carefully observant medical men aloof from surgical treatment is the operative mortality already referred to, and it is particularly unfortunate that until repeated disaster has driven the surgeon to a very careful and deep study of every phase of this subject the operative mortality is liable to cast serious discredit upon the procedure.

It has been the experience, as related to us by a number of medical men, that at some past period, not content with the results of hygienic, cytolytic serums and other forms of medicinal treatment, they were led on, by the comparatively brilliant results of certain surgeons, to turn for help to their surgical friends, only to find that the advice was fatal to their patients. Concluding that any treatment was better than this, these men returned to nursing their

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patients along, and, in each instance, it was some years before they again began to consider surgery as the best available solution.

But while the medical man was learning that ordinary surgery was not good exophthalmic goitre surgery, the surgeon was learning, in a large measure, how to recognize and avoid fatal errors. At present the confidence of medical men is being gradually restored, and they are again regarding surgery a lesser evil than the disease.

With regard to hyperthyroidism, surgery has been through a long and grilling trial, during the course of which the odds have not always been in its favor; but purely medicinal and hygienic treatment is not satisfactory, and cytolytic serums have not made good. We believe today that the rather general verdict is that though surgery alone is not the best treatment of the syndrome, the best cannot be effected without surgery until some better means is found, and that it is the surgeon's duty, and to the interest of the patient, the medical profession and himself, to foster by the surgeon's results the present attitude of growing confidence.

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## THE QUESTION OF FEES.

*The Medical Standard.*

'THERE has been a discussion of surgeons' fees in the New York *Times* that has really been interesting, since laymen and medical men alike have participated in it. Some of the arguments have been exceedingly ingenious, even if they have not quite carried conviction. Such an one is found in the letter of a contributor who signs himself "Visitor" and who is called by the editor an "eminent surgeon:"

"I am a surgeon, and have no sliding scale. Every operation of a certain kind justifies a fee of $50,000. If a man cannot pay it, I make him a present of the difference between that amount and what he can pay comfortably.

"A banker often pays the lawyer $10,000 for investigating the security of a set of bonds, and there is no question about the fee. How often will the same banker pay the surgeon $10,000 for his investigation of the security of a certain operation which saves life and bond business and all? Never, in my experience, without questioning the bill, injuring my reputation and causing me indirectly such a loss that I could better have treated him for nothing. The principle of fundamental character is that property is held to be more valuable than life. From a sentimental point of view, life is held to be more valuable, but basically, in nature's plan, property stands first.

"I have never heard of a case in which a surgeon of standing rendered a bill that was too large. Even the comparatively small bills are questioned by the rich to such an extent that we would rather care for the poor. I have seldom had a bill for $5000 paid with such good grace that it was any pleasure to receive the money. I have had thousands of bills for $100 paid in a spirit which made it a joy to receive the money. Why, then, do we not always send bills that will bring us joy with the money? It is because we think too highly of our profession to degrade it. Our duty toward the public, toward the patient and toward our profession stands in the way of our doing that. We do not need much money for our-

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selves, but we need much money in order to give to the poor that which the wealthy refuse to give or do not know how to give."

We have omitted a number of paragraphs from "Visitor's" letter, but those printed really present the central thought in the argument, which is that the surgeon is justified in charging the few enormous fees because he gives free treatment to the many. Around the latter service he throws the mantle of charity, with a certain smug self-approval of his own good works.

There is a false note in all this. This surgeon knows very well, as do all like him, that the charity work he does is rarely performed for sweet charity's sake. The dispensary, college and hospital appointments, which carry with them nine-tenths of this free surgical treatment, are eagerly sought by the ambitious men of the profession because they give opportunities for experience, prestige and preferment. These eminent surgeons also know that nine-tenths of the people who seek and secure this free treatment are able to pay something at least to the financially poor men of the profession, who are kept poor and are deprived of the experience and support they need by the hoggishness of their eminent brethren, who demand haloes for righteousness' sake!

Suppose we carry the argument of "Visitor" a little further. If it is worth $50,000 to relieve a millionaire of his appendix, it is worth just as much to cure him of typhoid fever; just as much to arrest an incipient phthisis; just as much (and in his heart he may say more) to cure his gonorrhea! Apparently among them the specialists would be "justified" in stripping any man of all he had simply because (as we all admit) life is the most precious of our possessions. The thing reduces itself to an absurdity.

Our surgeons' fees are high enough. It is quite unnecessary for these ingenious men to devise new plans for boosting them still higher. It would be far better to establish scales of prices so adjusted to the earning capacity of the different classes of society that the men who work for a small wage could pay their own way with the surgeon, just as they do at the grocery store, without taking leave of their self-respect.

## THE MODERATE DRINKER.

*Long Island Medical Journal.*

The presence of alcohol in some form from the beginning of recorded events has graced the table of hospitality, and its use through custom has become a seeming requisite of honor to the welcomed guest. The fleeting exhilaration consequent upon its use undoubtedly creates a spirit of cordiality and fraternalism; artificial, it is true, but charmingly delightful to the poor devil who, free from the stressing importunities called forth by his struggle for existence, finds himself in an atmosphere of merry abandon, roseate with opportunities and bewilderingly pleasant. Verbiage as light and frothy as hillocks of sea foam nestling upon the beach falls upon his ear as scintillating wit, and to him "For He's a Jolly Good Fellow" possesses a melody sweeter by far than Verdi's classic "Holy Mother Guard His Footsteps." We who have participated in such inanities and insanities for which, O Bacchus! you were responsible and we the willing worshipers, must in the future quaff the sparkling fluid servant to Moses' rod if we desire to preserve the highest standard of our natural endowments, ac-

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BALTIMORE WASHINGTON

cording to Col. Louis Mervin Maus, Medical Corps, U. S. A., Chief Surgeon, Eastern Division, who, in a paper entitled "Should Total Abstinence Be Required of Officers in the Military Service?" read at the meeting of the military surgeons of the United States held recently in Baltimore, forcibly advocated the adoption of the affirmative answer to his query. Col. Louis Mervin Maus commenced his dissertation by humorously alluding to his past minor transgressions against the law of total abstinence, thus disarming any possible criticism, and "many who came to scoff remained to pray," listened with rapt attention to the doctor's words.

He conclusively proved by competent scientific authority that former opinions of alcohol had been revolutionized through laboratory and psychologic research. We all recognize the lamentable effects of hard drinking, but that it is difficult to convince the moderate drinker—the man who drinks two or three times a day—that he exceeds the safety limit to body and mind. When warned he will reply: "Why! whiskey in moderation is a stimulant and food." A traditional fallacy. Exhaustive experimentation has shown that it is a depressant after its primary stage of excitement. The influence of alcohol on the nervous system continues from 24 to 72 hours, and affects thought and action during that period. It does not relieve fatigue through stimulation, but by deadening sensation. The typical effects observed in moderate drinkers are a weakening of the higher functions and a corresponding exaggeration of the lower ones; a loss of mental alertness and the finer conception of originality; a lowering of the moral standard and lessening of self-restraint; that it makes men less cautious and impairs judgment and ability to arrive at normal conclusions. The once brilliant mind fades away to be replaced by lowered moral tone. The health of cells depends upon the condition of the nuclei and protoplasm. Alcohol is a protoplasmic poison inhibiting cell growth, restricting the production of anti-bodies and neutralizing the action of the bacterial toxins in the blood. Sir Benjamin Richardson showed that under the influence of alcohol temperature was lowered from three-quarters to three degrees. Nansen and all other explorers inveighed against alcohol in frigid climates.

In summarizing, Dr. Maus said "that after a careful study of alcohol as a beverage he was unable to find one single beneficial or useful purpose it serves in the human economy; on the other hand, even in moderate quantities, it reduces everyone's efficiency and impairs mental and physical conditions. Medical officers, the proper performance of whose duties involve the safety and lives of others, should especially be debarred from the use of alcoholic drinks so as to conserve their mental capacities to the fullest extent. In view, then, of our knowledge of the subject, has the Government the right to prohibit the use of alcohol amongst public servants. Every officer who accepts a commission in the army and navy relinquishes in part his civil rights and personal liberty. In orders, commands and duty the Government provides ample pay and allowance, and obligates itself to pension officers on age and length of service or for mental and physical disability contracted in the line of duty. For this reason we hold that the Government has the right to require every officer and enlisted man to safeguard himself against disease and vicious habits inimical to health and efficiency. Sanitary orders are issued guarding by modern means

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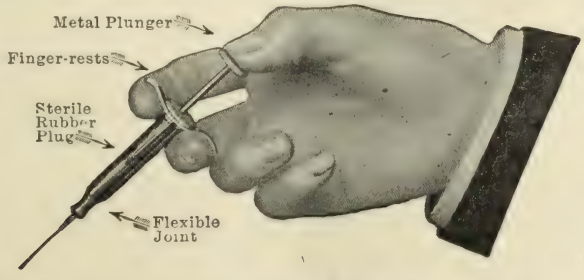


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against amebic dysentery, cholera, typhoid fever, smallpox and diphtheria. Why not enforce abstinence of alcohol, which is the underlying cause of venereal diseases, impaired health and non-efficiency in public servants? In answer to interference with personal liberty, one's rights only invite activities that are not detrimental to others or communities."

Few will attempt to controvert Colonel Maus' deductions that alcohol is not necessary to the human economy, that man maintains a better correlation of bodily metabolism when totally abstemious, that even in moderate quantities alcohol is destructive to all life. Logically, then, we must agree with the Colonel that when the lives of others—in fact, communities and counties—are imperiled by reduced efficiency of those in charge, the cause of this inefficiency should be removed. Military officers and medical men are ever the subjects of emergency calls involving life and death. There is no gainsaying the proposition that they should be in full possession of their mental powers when such a demand is made upon them. The practice of moderate or occasional drinking is not so bad in itself, but the temptation at times to exceed moderation is very great. Therefore, a habit of total abstinence is a safeguard. To look for universal teetotalism is but a chimerical, idle dream, but to hope for teetotalism amongst men of intellect entrusted with gravest responsibilities, possessing a conscientious regard for a divine duty, is not a far-fetched thought. It may be slow of growth, but conscience will ripen its fruition and the ideal be realized.

## COMMISSIONS TO INVESTIGATE ANIMAL EXPERIMENTATION.

*Long Island Medical Journal.*

Many practitioners in this country have considered it unnecessary to fight the various propositions made by the anti-vivisectionists to have committees appointed to investigate laboratories where medical research is being carried on. They can see no harm in allowing these investigations to be carried on. They do not realize, however, that the committees appointed for such investigations are generally made up of persons who are entirely ignorant of the true purpose of research work and incapable of judging the degree of suffering which the experiments cause. Even this objection has been overcome in England, and commissions have been appointed which are capable of judging such matters wisely.

The result of these investigations in England has twice been favorable to the continuance of animal experimentation, and yet, despite the fact that the verdict of the commissioners was overwhelmingly in favor of the experimenters, they supply the illogical and untruthful leaders of the anti-vivisection movement with much material for misrepresentation.

In 1875 Queen Victoria appointed the Royal Commission to investigate the medical laboratories of Great Britain, and that commission found no abuse of the privileges granted to the medical men. The report, however, was followed by the passage of a restricted law which has greatly hampered research work in England. All this, of course, seems illogical, and yet it is a fact that if these commissions are appointed the result of their investigations, whether they are favorable or not to the research laboratories, still have acted harmfully to the profession.

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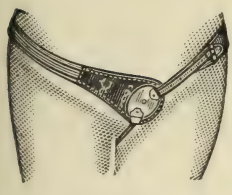

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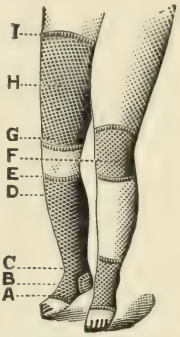


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This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

### Reading Notice.

IT is during the spring months more particularly that the physician is called upon to treat patients, who, though not ill enough to be in bed, are not at all well. Their appetite is capricious, they sleep indifferently, or even if they sleep soundly they are not refreshed, and in the morning they are almost as fatigued and ill at ease as was the case on retiring. Upon awakening there is frequently an aching sensation in the loins, sometimes in the lower limbs, which may partially wear off as the day progresses, but there is at all times a vague, undefined, uneasy painful feeling.

The symptoms are very much like those experienced in malaria, but the causes are entirely different and a different treatment is necessary.

This condition arises from the fact that in the spring the eliminative functions do not present their usual activity, owing to the torpor and locked-up secretions which have existed during the winter months, when the skin neglects its duties and the kidneys are overworked.

If the condition remains neglected the probable result will be sooner or later a pronounced attack of rheumatism or grippe in one or another of its forms. All that is needed to induce such an attack is a sudden change in the weather or the exposure on the part of the patient to cold or wet, or to a combination of

both. This is due to a latent diathesis to which every adult is liable.

The necessity of a powerful eliminative in every prescription for rheumatism and grippe is self-evident. While anti-pyretics and anti-periodics may slightly stimulate the excretions and relieve congestion, thereby controlling certain features of the disease, a complete cure cannot be expected until the poisons are thoroughly eliminated from the system and the diseased organs enabled to resume normal functions.

In the treatment of all rheumatic, neuralgic and grippy conditions, Tongaline, by promoting the absorptive powers of the various glands which have been clogged, and by its stimulating action upon the liver, the bowels, the kidneys and the skin, will relieve the pain, allay the fever, eliminate the poisons, stimulate recuperation and prevent sequela.

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**The Tonic Effects of Hypophosphites.**

THE choice of a tonic for the young is determined by special considerations, because their requirements differ in several important respects from those of adults. The interference with nutrition that arises from acute pyrexial infections is attended by particularly serious consequences in the young, because their growing tissues are less stable and their mineral constituents are less "fixed," so that the disintegrating effects of exaggerated oxidation are much more rapidly produced.

The requirements of the youthful organism in the matter of inorganic salts are much greater than those of later life, because not only has the ordinary wear and tear to be provided for, but also the demands of growth. Acute disease, as we know, is characterized by more rapid oxidation and exaggerated metabolism, and the latter, in turn, is associated with wasteful leakage of the mineral constituents of the tissues.

Depleted of their mineral constituents, the tissues protect themselves as best they can by drawing on the organic reserves, especially the bones, so that pyrexia not only entails arrest of development, but also of positive denutrition.

Then, too, the blood pressure in the young is normally low compared with that of the adult, so that the depression resulting from the ravages of disease is particularly well marked.

Apart from acute disease, children suffer from a series of affections associated with chronic malnutrition. Dyspepsia, rickets, scurvy-rickets, etc., are all characterized by impoverishment of the tissues, so that although less rapidly induced, the constitutional changes are, roughly speaking, the same. The consequences, however, are more serious, because they are more protracted. The lack of mineral salts in general, and the compounds of phosphorus with the earthy bases in particular, leave the skeleton abnormally plastic, so that the traction of the muscles produces deformities of the thorax and limbs, which deformities are likely to become permanent unless speedily remedied.

The recognition of this condition affords the requisite data for the choice of the most suitable tonic. The weakly infant is the victim of more or less pronounced demineralization of the tissues, and the indication is that it should be provided with the material for remineralization in the form best adapted for immediate assimilation. At the same time, tone must be restored to the vascular system and to the muscles, in order to secure the performance of the vital functions.

Now, the salts of which the youthful organism stands most in need are compounds of phosphorus, and, as its capacity for assimilation is limited in regard to any particular salt, the phosphorus must be combined with various bases. Of all the phosphorus compounds, the hypophosphites are recognized to be the most readily utilized by the tissues; hence a compound syrup of these salts will fulfil every indication.

The vasotonic element—strychnine—may advantageously be associated with these salts, as it is in Fellows' syrup of the hypophosphites.

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just as salt is a food and not a mere condiment. Without salt the tissues are unable to assimilate and to retain the elements indispensable to their nutrition and growth. Under the influence of the hypophosphites they not only gain in weight, but also in density, owing to the fixation of inorganic salts, and so the balance of nutrition is restored.—*Alfred S. Gubb, M.D., France, in the Medical World.*

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There are other uses to which Lilly's Lubricating Jelly may be advantageously subjected. Antiseptics and frequent scrubbing of the hands are likely to produce a dermatitis. The jelly should be used to soothe the skin and prevent irritation. Certain skin diseases, such as pruritus, may be greatly mitigated by the application of the jelly. It is soothing and healing, and can be used with much benefit in the eruptive fevers in which there are itching and irritation of the skin. Further information can be had by addressing the manufacturers, Eli Lilly & Co., Indianapolis.

### Facts About Phylacogens.

PRACTITIONERS who have a fondness for figures, and who want definite, first-hand knowledge of what the Phylacogens are accomplishing in the way of actual clinical results, are urged to turn to the display announcement in the current issue of this JOURNAL bearing the signature of Parke, Davis & Co. Here, under the title "The Value of the Phylagogens," one finds the results in 4148 cases of infectious diseases that have been treated with Phylacogens. One also reads in detail what is credited to each individual Phylacogen. For instance, you may be interested in rheumatic affections. You see at a glance that a certain number of cases have been treated and reported; the same glance tells you how many of them were treated successfully. This is equally true of pneumonia cases, erysipelas cases, gonorrheal cases, mixed-infection cases. Figures are apt to be tiresome. These figures are not so; they tell what every practitioner of medicine wants to know or should know. We commend the announcement to our readers.

### Ferruginous Elements of Bovinine.

THE blood, the nourishing fluid which conveys to our tissues the elements necessary to life and development, owes one of the most important of its properties to the iron contained in its red corpuscles. Consequently, when iron is lacking in the organism, the blood becomes impoverished and strength rapidly disappears. It then becomes necessary to furnish to the blood, under the form of a medicament, the iron that it has lost. Bovinine answers this purpose very effectively. In its combination with the other elements the iron loses its astringency and its disagreeable taste without there being any lessening of its medicinal properties.

Bovinine is tolerated by all stomachs. It is

an excellent tonic and reconstituent which is employed with success in the treatment of anemia and chlorosis, pallor, etc. Bovinine should be taken before or after meals.

As a reconstituent in affections of the stomach, pallor, lymphatism, slow convalescence after confinement, etc., it is a nutritive tonic without peer.

The value of a nutritive tonic prepared as Bovinine is in cases of disease and during convalescence can hardly be overestimated, as the elements are in a condition ready for assimilation with very little exertion on the part of the enfeebled digestive apparatus.

Bovinine may be administered with perfect safety to the most fastidious patient, to those with delicate stomachs and to children. It does not produce nausea, and is entirely free from bitterness or unpleasant after-taste peculiar to medicines in general. Palatability is secured by appropriate and delicate flavoring, which is carefully estimated according to normal gastric digestion. The preparation is permanent in ordinary climates, and loses none of its therapeutic properties from age.

**Obstetrical Charts in Colors.**

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**The Sequelae of La Grippe.**

AMONG all of the various acute and exhausting illnesses that afflict mankind, there is none that so generally results in distinct prostration as epidemic influenza or la grippe. Even the grippal infections which are uncomplicated or unaccompanied by serious organic changes are more than apt to leave the patient in a thoroughly devitalized condition after the acute febrile symptoms have subsided. It is for this reason that the treatment of la grippe convalescence is of special importance. The anemic, debilitated, depressed patient requires a systemic "booster" that will not only stimulate, but revivify and reconstruct. It is distinctly wise, in such cases, to commence vigorous tonic treatment as early as possible, preferably by means of Pepto-Mangan (Gude), the hemic builder and general reconstituent. This standard hematinic increases the vital elements of the circulating blood and, by increasing the appetite and improving the absorptive and assimilative functions, quickly restores both hemic and general vitality.

**The Nervous Trials of the Alcoholic.**

THE physician who has not yet employed it as a means of relief in the nervous element of alcoholism will be most agreeably surprised the first time he resorts to Pasadyne (Daniel's Concentrated Tincture of Passiflora Incarnata) in the condition mentioned.

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**A Seasonable Reminder.**

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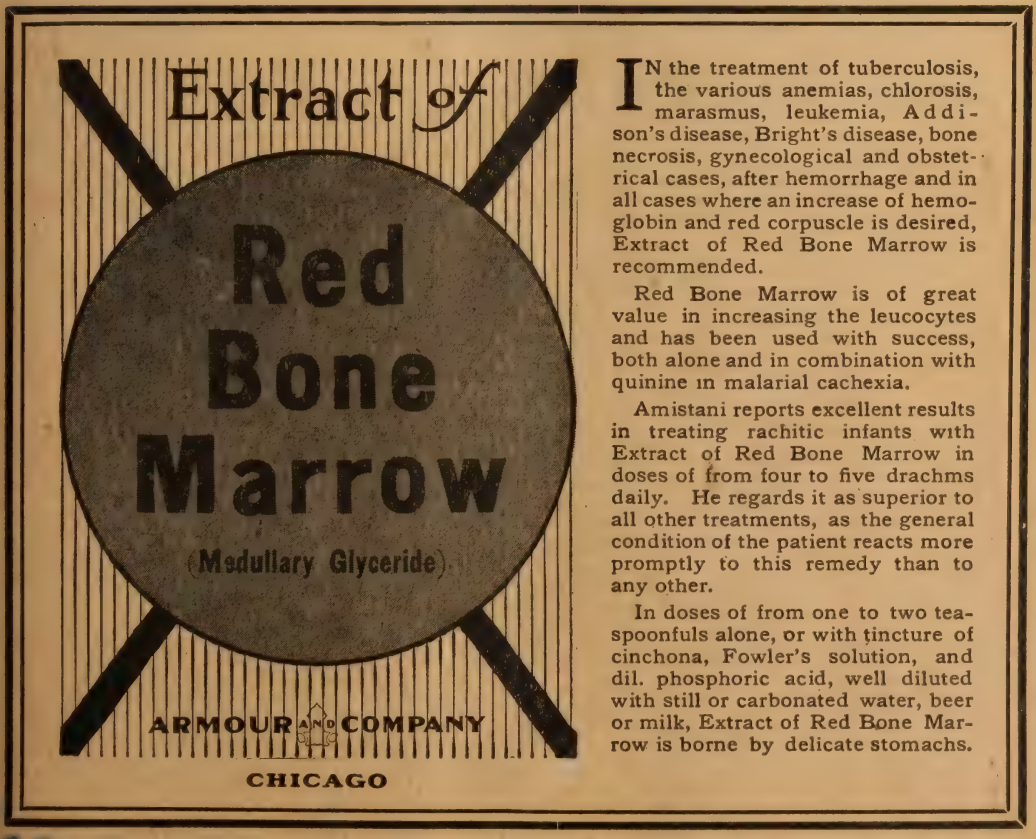


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# *Editorial Comment.*

## THE STRAIN OF MODERN LIFE.

*The American Practitioner.*

No doubt the stress and strain of life today is conducive to nervous complaints, as well as to arterial, cardiac and gastrointestinal disturbances. We are living in an age of rapid development; the demands of commerce, active and radical changes in manufacturing industries, progress in industrial and other sciences make demands upon the activities and technical knowledge that only the strong and mentally well equipped can meet. Others, those without special training or skill, those not mentally or physically equipped, the mediocre, small man in his efforts to keep pace with the development, growth of the strong, fall behind and are soon left in the hopeless majority. The scale with which things are carried on, the ceaseless onward march of events will not even tolerate the silent spectator, for to stand still is rapidly to

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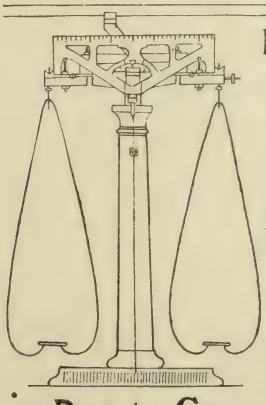

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lose position, wealth, a place. And yet with all of this hurry, one is amazed at the outward calm, the poise of the man of affairs of today. He, at least, is not agitated, comes and goes, controls, whips into line opposing forces, determines in a day alone enterprises that it would have taken a committee or board months to bring about but a generation or two ago, and all without noise. And yet it is claimed that circulatory disturbances, gastric complaints are ever in evidence; that men are destroying themselves because they are especially much too mentally active. They are scolded, berated, warned that they are going the pace that kills. They take too little rest, eat and drink too much; that arteriosclerosis, cardiac and gastric disturbances will surely follow. We read that man is old, worn out at 60 years of age, but statistics prove that the average length of life is between six and seven years longer than a century ago. Surely man is better housed, better fed and clothed, better educated, has more and varied amusements, pleasures; is as refined, can travel further and see more, is handsomer, more charitable; no more selfish than a few generations since. There is less to fear from disease, epidemics, wars; better and more humane treatment when sick or injured. Wives and children are better cared for; better educated, dressed, entertained; are healthier, happier, more beautiful than in the history of the world as we know it. True there are the neuropathic sanitariums, while men die from circulatory ailments, arteriosclerosis, kidney trouble, intoxication of various kinds; in rare instances we are called upon to treat gout—not as often by far as in ye olden times—but, like the poor, these are always with us. There are always those who are ever ready to proclaim from the housetops, or through the press over their names, troubles, evil doings, wrong living, and also ever ready to offer correct advice as to remedying these and all other evils, who never think of practicing what they preach. We believe in educating the people in hygiene and prophylaxis, but would not they be happier, more content if they knew less of the pathology and treatment of the ills they are forever assured they have or will have?

Verily this is one beautiful, very beautiful world, where we can and should live like sane men and women, temperate in all that we do, helpful to those less fortunate than ourselves, keeping body, mind and soul clean, thus insuring health and happiness.

O blessed health; thou art above all gold and treasure; 'tis thou who enlargest the soul, and openest all its powers to receive instruction, and to relish virtue. He that has thee has little more to wish for; and he who is so wretched as to want thee wants everything with thee.

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## ALEXIS CARREL, PRIZE WINNER.

*Medical Summary.*

The Nobel prize has again been awarded. This plum amounts in cold cash to about $40,000, and goes to Dr. Alexis Carrel of the Rockefeller Institute. Carrel is a young Frenchman and has been in this country only a few years. While his research work has been along broad surgical and scientific lines, his special field has been in the transplanting of organs and tissues. His work in uniting blood vessels has stamped him an artist in this line of

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endeavor. The problem of uniting arteries without forming a clot has always been a delicate one, but Dr. Carrel has evolved a technique by which this difficult feat is accomplished with a modicum of success. In his vivisection work he has incorporated the heart of a small dog into the neck of a larger dog, bringing about synchronous action of the two cardiac organs and thus literally making "two hearts beat as one." His work in plastic surgery has been quite marvelous, from the reports we read. Persons suffering from the loss of bones or from destructive bone lesions have had the healthy bones of animals or other persons incorporated to take the place of those whose function is destroyed, and these are said to grow and be of the same service as those that have been displaced.

Dr. Carrel is of the opinion that the organs and tissues of healthy persons who meet with sudden death—as in case of railroad wrecks and other disasters—should be preserved for the purpose of rehabilitating persons who may stand in need of just such organs and tissues. Such material, he states, may be employed days or weeks after, provided it is kept under right conditions. This scientist is of the opinion that almost every organ may be thus transplanted. In his work on animals many transplantations of organs were made, employing organs and parts of organs that had been dead and preserved for weeks.

## SURGERY AND THE LAW.

*The Medical Sentinel.*

The strong arm of the law has been raised in protection of the normal appendix, and the Colorado surgeon who removes this appendage must show evidence of its being diseased, or stand arrest. This stringent measure has become a necessity, owing to the tendency of surgeons before concluding a laparotomy to remove this apparently useless organ, and thus add a needless hazard to that of the original operation.

If this policy of conservation would only be extended to cover other organs, its usefulness could be added to a hundred-fold. Let it embrace the normal ovary or even slightly cystic ovary, which is still being ruthlessly extirpated in spite of its dire effects on the future well-being of the unfortunate patient. It could also serve a field of usefulness were it to include the useless and wrongful removal of every tonsil that appeals to the operating specialist as enlarged.

Let the law also include those innumerable operations where a normal uterus is dilated and its mucosa scraped and curetted for the simplest menstrual disorder. Were such a law in effect we can predict a sudden return to conservative surgery on the part of numerous operators, who take pride in their gallery-playing radicalism.

## HEREDITY AND DISEASE.

*The American Practitioner.*

That the evidence on inheritance in man is often unsatisfactory is well known to those who have given the subject the most careful study. The reasons for this lack of trustworthy information are many, as was pointed out recently by Professor Hickson at a

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meeting of the Manchester Pathological Society, *Medical Press,* November 13, 1912. These reasons seem to be that civilized man presents many difficulties for investigations. He differs from all other animals in the extraordinary length of his period of juvenility; reaching physical maturity at about 15 years of age, mental maturity much later. Man appears to require for his proper development a long period in which he may be influenced by his environment; he is much more a creature of environment than are other animals. It thus becomes difficult to distinguish between innate and acquired characters. Another difficulty is that man is a very slow breeding animal; it is thus difficult to get a sufficiently large number of cases of transmission of a particular character. Few statistics include more than three or four generations, or from 100 to 150 individuals. In investigations of certain vegetable and the lower orders of animal life, peas or mice, for instance, biologists are not satisfied with less than several thousand individual specimens. There is a third difficulty, not peculiar to man, the possibility of transmission of characters by the placental blood. Such characters are, of course, not innate. This term can only be applied to characters transmitted through the germ cell. For these reasons we are always sceptical of statistics bearing on the transmission of acquired characters. It is very doubtful if a hard and fast line can be drawn between fluctuations and mutations. There are, undoubtedly, mutations which are transmitted without blending, but there are others in which there appear to be only a difficulty of blending. In the case of an extra digit, blending could only mean the production of an extra half digit. Now, experiments on poultry have seemed to show that the transmission of an extra toe obeyed Mendelian laws, but on analysis of the figure it appears that many of the extra toes are only half toes, which can equally well be interpreted as blending.

## A REWARD FOR COLONEL GORGAS.

*The Medical Standard.*

The *Journal of the American Medical Association* is inspired by the bill now pending in Congress to raise the rank of Colonel Goethels, the administrative officer of the Panama Canal, to that of major-general to make a plea for an equal reward for Colonel Gorgas, who by his efficient sanitary work made the whole thing possible. It also suggests that Congress might well reward these two men further by giving them each a generous cash donation. The latter idea is a good one—it has our endorsement—but just imagine a Democratic Congress doling out dollars to non-political officeholders. Preposterous! A more practical plan to reward Colonel Gorgas is to help secure for him the Noble prize in medicine. If ever a man earned this honor, he has. We hereby place the Colonel in nomination.

## WHAT HAS BECOME OF THE OLD MAN?

*Medical Summary.*

It is seldom that we now see a toothless, doddering old man, and the feeble old woman garbed in funeral black is almost as rare. And still longevity is on the increase. In the words of the breakfast food ad., "there's a reason." Good dentistry is wide-

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spread and now more reasonable in price than formerly, and almost everybody avails himself of it. Good teeth and clean mouths are dissipating many diseases. Ophthalmology is now so perfect that anyone with a semblance of vision left may be fitted out so that he can "read the finest print." The daily paper and our wealth of general literature are within the reach of all, and the rejuvenating effects upon oldish people cannot be denied. The cosmetic effects of good teeth and the ability to see and hear well are important; we do not feel so old, and this cheerful introspection tends to keep us young. Elderly people no longer dress and disport themselves in the serious manner they once did. The morbid and ascetic ideas of a former age have given way to the gospel of optimism and good cheer. As a people we have just as much true religion in our hearts as ever prevailed in any age, but self-abnegation has given way to the real joy of living. Old people now keep young by remaining alive and in touch with the vital and interesting things of the world. We have eliminated much from our lives that is morbid and uncanny, and cherish a desire to live until we die. Fewer people now become senile and burdensome to others.

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## DUST, THE UBIQUITOUS.

*The American Practitioner.*

We have gotten rid of many evils that annoyed and caused injuries to our ancestors, but there are still left nuisances, great and small, which make life almost unbearable. It is not necessary nowadays for one to wear a sword for protection, or to envelop one's self in a cloak with which to conceal his identity; nor are we in danger of being knocked on the head by a peeved neighbor, albeit we have the highwayman, dust and noise very much in evidence. Officers of the law give us a large measure of protection from the highwayman, but dust and noise are really ubiquitous. How to nullify these vexatious evils is a question which has received much thought, but as yet no solution. Competent statisticians have estimated that there are four thousand millions of dust particles in an average puff of cigarette smoke; while scientists declare that while chemically pure water is a non-conductor of electricity, if one grain of salt be added to a hundred tons of water, the electric current will link each molecule of water to its neighbor, the bridge being the infinitesimal quantity of salt. We thus realize what is meant by the expression divisibility of matter. To realize this and know of all the noxious and nauseating substances contained in the dust in our streets, homes, places of amusement, etc., we wonder with increasing horror why the chief method of getting rid of dust is to disturb it from its resting place and send it spinning through the air on its maleficent mission.

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Information connected with medical examinations and licensure by addressing Secretary J. McP. Scott, Hagerstown, Md.

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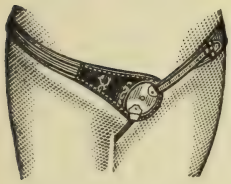

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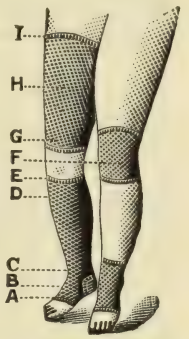


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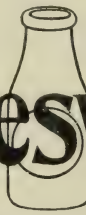

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### Danger Due to Substitution.

HARDLY another of all the preparations in existence offers a wider scope to imposition under the plea of "just as good" than the scientifically standardized Eucalyptol.

The most recent fraud practiced in regard to this product is an attempt to profit by the renown of the firm of Sandner & Sons. In order to foist upon the unwary a crude oil, that had proved injurious upon application, the firm name of Sandner & Sons is illicitly appropriated, the make-up of their goods imitated, and finally the medical reports commenting on the merits of their excellent preparation are made use of to give the desired luster to the intended deceit.

This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

### The Phylacogen Treatment for Rheumatic Infection.

SINCE the announcement, some time ago, of the large percentage of recoveries following the use of Rheumatism Phylacogen in over thirteen hundred cases of rheumatism—results reported by clinicians in various sections of the United States—interest in this new bacterial derivative has developed to a very marked degree. Physicians everywhere are demanding information in regard to this therapeutic agent: an agent which appears to produce recoveries in at least 85 per cent. of cases—and that, too, in a disease that for hundreds of years has been a stumbling-block to the medical profession.

What is the scope of the new product? In what forms of rheumatism is its use indicated? These questions are being asked. We are glad to be able to answer them—in a general way, at least. From the literature on the subject it is learned that Rheumatism Phylacogen is applicable to acute rheumatic fever, acute articular rheumatism, acute inflammatory rheumatism, chronic rheumatism, rheumatic arthritis, rheumatic myalgia, rheumatic neuralgia, rheumatic iritis, lumbago, sciatica—in short, to all pathological conditions due to infection by the Streptococcus Rheumaticus. From the same source are gathered these suggestive hints upon the subject of diagnosis:

"True rheumatism must be differentiated from septic arthritis, tubercular arthritis, gonorrheal arthritis, gout, arthritis deformans, traumatisms, etc. The failure of Rheumatism Phylacogen, properly administered, affords presumptive evidence of an error in diagnosis." In the case of chronic rheumatic conditions stress is laid upon the fact that continuous treatment for three or four weeks may be necessary. If, however, the patient does not show continuous improvement, it is urged that the treatment be discontinued and a careful re-examination made so that the exact pathological condition may be determined.

Other phases of the Phylacogen therapy—as questions of dosage, reactions, methods of administration, etc.—might very properly be considered at this juncture. These, however, are subjects that cannot be adequately discussed within the limits of this article. They are fully treated in the Phylacogen literature, issued by Parke, Davis & Co. and procurable by any physician upon request to the home offices at Detroit, Mich.

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**Cod Liver Oil in Bronchial Inflammation.**

THE great value of cod liver oil in chronic bronchial inflammations is so thoroughly accepted by the profession that the only question which ever arises in regard to its use is the form in which it may be best exhibited. In regard to a suitable form of administration, the great difficulty has been to secure palatability without loss of therapeutic power. Cord. Ext. oi Morrhuae Comp. (Hagee) combines these two requisites, as a result of which advantage it has secured the support of a large proportion of the profession.

In the bronchial ailments of young patients especially, it will be found a most satisfactory agent.

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**The Elimination of Opium's Untoward Phenomena.**

WERE it not for its several disagreeable features, which are sufficiently weighty to make one hesitate before employing it, opium, of course, would be the ideal analgesic. Unfortunately, however, along with its analgesic effects, opium exerts those well known phenomena which tend to limit its usefulness as a pain-relieving agent.

But with the discovery of processes by which it is possible to eliminate the convulsive and narcotic principles of the drug, Papine (Battle) became possible, and with a wider therapeutic application than opium.

In the manufacture of Papine the several objectionable qualities of opium have been eliminated, the finished product representing the analgesic and sedative properties only of this valuable drug.

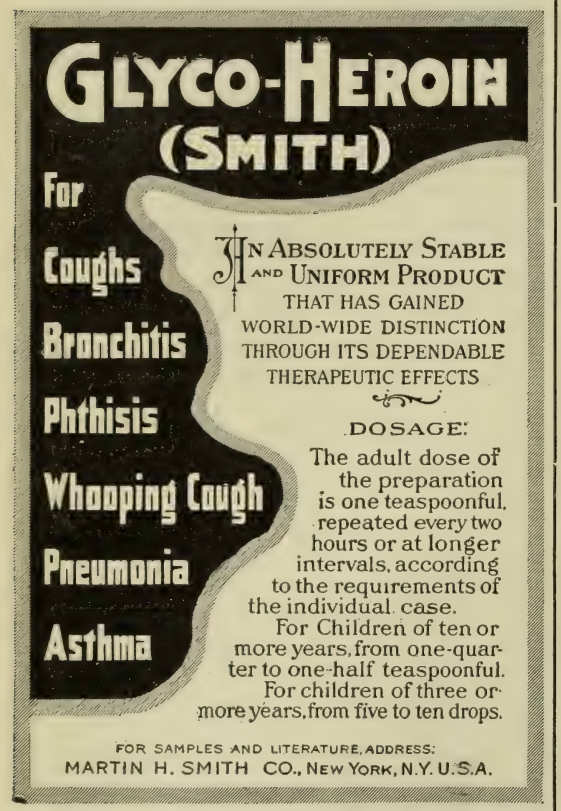
In view of this, the superiority of Papine over opium and its alkaloids cannot be denied, for although offering to the patient the positive analgesic properties of opium, it does not at the same time bind up his bowels or subject him to its other disagreeable effects. The utmost care is taken in the manufacture of Papine, and it is fully believed that it offers every possible advantage over opium.

---

**Selection of a Tonic.**

THE greater care and thought being devoted to the use of remedies in disease is heartily to be commended, and there can be no question but that the vastly superior therapeutic results that medical men are uniformly obtaining today are the direct outcome of the broader grasp of drug action. Take, for instance, the successful application of tonic medication. No physician at the present day would think of administering any potent restorative or reconstructive remedy without paying due consideration to the following essential details:

*First.*—The avoidance of any remedy which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from its nature or ingredients would tend to unduly stimulate or excite the higher nerve centers.

*Second.*—The avoidance—except when specifically indicated—of any remedies which suddenly and markedly raise the blood pressure.

*Third.*—The avoidance of reconstructive measures, except in rare instances, which do not have a well-defined permanence of action, or which must be constantly increased in quantity, or continued indefinitely, in order to secure their beneficial effects.

*Fourth.*—The avoidance of remedies containing drugs which are apt to produce dangerous or toxic effects as a result of some possible idiosyncrasy on the part of the patient.

Careful investigation on the part of the careful practitioner will enable him to see that of all the tonic remedies at his command, Gray's Glycerine Tonic Comp. is one of the few that can be freely employed with certainty that all of the foregoing requirements have been met.

As a matter of fact, clinical experience has clearly demonstrated that one of the strongest features of Gray's Glycerine Tonic Comp. is its practical freedom from any contraindication of age, sex, season or personal idiosyncrasy. It is a thoroughly reliable tonic that accomplishes its effects solely through stimulating the physiologic functions of the body. As a consequence, its whole action is to restore a nearer normal balance between physical waste and repair; in other words, the proper nutrition of the whole body. Under its use every function is promoted and helped to do its normal amount of work, with all that this means in the maintenance of physical health and vigor.

### Lilly's Liquid Soap.

A THOROUGHLY efficient liquid soap is invaluable to the physician and surgeon. It has the advantage of being readily miscible with water, absolutely clean and conveniently carried in the physician's case. The soap that is available in the house to which the physician is called may not be desirable; in fact, it may be objectionable. Liquid Soap can be quickly and thoroughly applied to the parts to be washed. It must be a detergent, non-irritating and sufficiently liquid to be promptly delivered from the container.

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### Safeguarding Patients Against the Cathartic Habit.

IT IS a growing opinion among medical men that powerful cathartic preparations are often used too freely and for too long periods by patients afflicted with constipation. Many purgatives by their drastic action actually diminish biliary secretion, and thus tend to increase rather than correct habitual constipation. The evil effects from their indiscriminate use are usually due to the thoughtlessness of patients who are not content unless they obtain vigorous action. This "cathartic habit" while producing the effect which the patient thinks is desirable often leaves the secretory functions

of the liver in an enfeebled and exhausted condition, so that a reactionary constipation is bound to follow. In treating chronic constipation the physician will find Chionia a most valuable adjunct combining it with the chosen cathartic and gradually diminishing the dose of the cathartic employed as improvement follows. The administration of Chionia should be continued some time after the cathartic or purgative has been discontinued. Under such treatment the hepatic organ will gradually resume its normal functions and a restoration of a healthy condition, particularly of the bowels, will be the result.

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**Reduction of Nervous Tension.**

One of the most positive therapeutic powers possessed by Pasadyne (Daniel), the Concentrated Tincture of Passiflora Incarnata, manifests itself in states of high nervous tension. As a rule, the sufferers are poorly equipped with moral resistance, and consequently it is of the highest importance in choosing remedial measures to guard against agents which might establish a habit. In using Pasadyne (Daniel) the physician need not give this possibility any heed, for it is quite free from such a disadvantage. In a wide variety of nervous affections Pasadyne (Daniel) is of the utmost value, which is further enhanced by its freedom from evil consequences. A sample bottle may be had by addressing the laboratory of John B. Daniel, Atlanta, Ga.

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**Bovinine as Hematic and Nutrient Tonic.**

For anemia, chlorosis, cachexia, neurasthenia, nervous depression, low vitality, debility during convalescence from long illness or surgical operations, ulcers and skin grafting; in the maladies of old age or resulting from faulty nutrition; in lassitude and conditions with no special disorder, except a distaste of food, physicians will find Bovinine, administered before meals, will excite appetite and promote digestion.

Bovinine is an aromatic liquid, presenting *ferrum* in organic combination, is readily ingested and increases the hemoglobin in the red blood corpuscles, is free from astringent properties, and will be tolerated better than the inorganic iron compounds. With it we have combined, for nutrient properties, all the essential elements of nutrition in a form that is easily absorbed by the stomach, acts as a stimulant to the functions of nutrition, and is most serviceable in maintaining cell metabolism. For children debilitated through nervous waste or suffering from rhachitis, marasmus, etc., and in convalescence from fevers, Bovinine will restore appetite and serve to stimulate the vital processes.

Physicians will find, upon careful clinical observation, that the claims made for Bovinine are fully justified. It is acceptable to the most fastidious, and can be administered for long periods without causing any disturbance of the digestion.

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**The Opinion of a Conservative Man.**

Dr. Henry Herman of New York city says: "While there probably never will be a remedy which will act with equal efficiency in all cases, the results which I have obtained with Glyco-Heroin (Smith) in a number of different and obstinate cases of cough, enable me to express myself as fully satisfied that it is an efficient respiratory sedative and expectorant."

We might add that this has been our observation. The sedative and expectorant properties of Glyco-Heroin (Smith) are, however, by no means the only attractive elements of that product; it is a splendid febrifuge as well.

---

**The Pneumonia Convalescent.**

In spite of all of the modern advances in scientific therapy, and the improvements in the general handling and management of acute infectious diseases, acute lobar pneumonia still deserves the title ascribed to it by Osler: "The Captain of the Men of Death." There are, however, especially during the fall and winter months, many cases of the lobular or irregular pneumonia that so often complicates or follows la grippe. When this condition supervenes it is more than likely to follow a sub-acute or chronic course, and convalescence is frequently long delayed. Under such circumstances, in conjunction with treatment designed to hasten resolution, a general blood tonic and vitalizing agent helps materially to shorten the convalescent period. Pepto-Mangan (Gude) is of much value in this field, because it not only increases the solid elements of the blood, but also acts as a true tono-stimulant to the organism generally. As Pepto-Mangan is free from irritant peroperties and constipating action, it is especially serviceable in the reconstructive treatment of the devitalization following the pneumonia of the aged.

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# Medical Items.

The Court of Appeals has confirmed the judgment in favor of Dr. Henry Charles Ohle against the Maryland Casualty Company for $7500. Dr. Ohle lost his eyesight while engaged in professional work. The verdict is noteworthy as it establishes the right of a physician to claim damages for injuries received during the life of an accident policy, even though the results are not fully known until after the expiration of the policy.

Dr. Chauncey T. Scudder is conducting a sanitarium at Evergreen Place and Palmer avenue, Arlington. "The Arlington Rest" is devoted to the care and treatment of drug and alcoholic habits and nervous diseases.

Dr. D. C. Miller, former State Senator from Washington county, was hurt in a runaway accident at his home, near Mason and Dixon. The horse he was driving ran into a fence and Dr. Miller was thrown out of the buggy and struck his head on a jutting rock. One cut under his eye required three stitches.

Dr. H. Arthur Mitchell of Elkton, Md., has been commissioned captain of the Medical Corps and assigned as sanitary officer of the First Brigade, Maryland National Guard.

Dr. and Mrs. Henry Barton Jacobs of 11 West Mount Vernon Place have opened Uplands, their country place near Catonsville. Later they will go to Newport, where they will spend the summer.

Dr. Eric Gould, London, England, who is making a round of inspection of American hospitals, paid a recent visit to Baltimore.

Dr. William H. Welch and Dr. Eugene F. Cordell of Baltimore have been elected honorary members of the Royal Society of Medicine, London, in the Section of History of Medicine.

Dr. Arthur Wegefarth fractured his leg near the ankle while boarding a street car on May 6.

After delivering the Sillman Lectures at Yale University, Sir William Osler returned to Baltimore for a few days, and on May 5 delivered an address to the students of Johns Hopkins University, and also a lecture to the nurses.

The sixtieth anniversary of the granting of the charter to the trustees of the Sheppard Asylum, Towson, by the Maryland Legislature in May, 1853, was celebrated at the Enoch Pratt Hospital, May 8-10. On the first day addresses were made by the following: Dr. Edward N. Bush, Dr. Edward D. Fisher, New York city; Dr. William Rush Dunton, Jr., Towson. After an inspection of the hospital, a buffet luncheon was served at the Casino at 6.15 P. M., and in the evening an address was delivered by Dr. Adolph Meyer, director of the Phipps Psychiatric Clinic, followed by papers by former members of the staff. On the evening of the second day the principal address was delivered by Dr. Edward Cowles, Boston, followed by several papers on technical subjects by former members of the staff. The third day was devoted to a bazaar for the sale of work of the handicraft classes and to field sports.

### MARRIAGES.

Raymond Bartlett Morris, M.D., Johns Hopkins Medical School, '10, of Olean, N. Y., to Miss Mary L. Parrish of 2801 St. Paul street, Baltimore, at Baltimore, May 14, 1913.

Louis N. Burleyson, M.D., University of Maryland, '91, of Concord, N. C., to Miss Alice R. Boylan of Baltimore, at Baltimore, April 12, 1913.

Oscar Richard Fletcher, M.D., University of Maryland, '08, of Sanford, Va., to Miss Nancy Virginia Taylor, at Temperanceville, Va., April 17, 1913.

Charles Overton Burruss, M.D., University of Maryland, '06, of Fredericksburg, Va., to Miss Margaret Byers, at Sharon, S. C., April 17, 1913.

### DEATHS.

Jacob L. Noble, M.D., University of Maryland, '76, a member of the Medical and Chirurgical Faculty of Maryland, formerly health officer of Caroline county, Maryland, died suddenly at his home in Preston, April 29, 1913, from valvular heart disease, aged 63 years.

John W. C. O'Neal, M.D., University of Maryland, '44, died at his home in Gettysburg, Pa., April 24, 1913, from senile debility, aged 92 years. Dr. O'Neal was a veteran of the Civil War.

Conrad P. Strauss, M.D., College of Physicians and Surgeons, Baltimore, '87, died at his home in Baltimore, May 2, 1913, from carcinoma of the throat, aged 47 years.

William C. Carson, M.D., University of Maryland, '56, died at his home in Port Deposit, Md., May 15, 1913, aged 80 years.

# Children Better Without Coffee

In childhood the emotional nature is peculiarly susceptible to stimuli, mental and material.

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A level teaspoonful makes it right for most persons. A big cup requires more, and some people put in a heaping spoonful, temper it with a large supply of cream, and it has a snap and go which pleases some palates.

Experiment until you know the amount that pleases your taste and have it served that way.

The *Clinical Record*, for physician's bedside use, together with samples of **Instant Postum, Grape-Nuts** and **Post Toasties** for personal and clinical examination, will be sent on request to any physician who has not yet received them.

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Surgeons have frequently been obliged to perform delicate operations with insufficient light on the patient, and in many cases the surgeon's head has been subjected to an intense heat caused by radiation.

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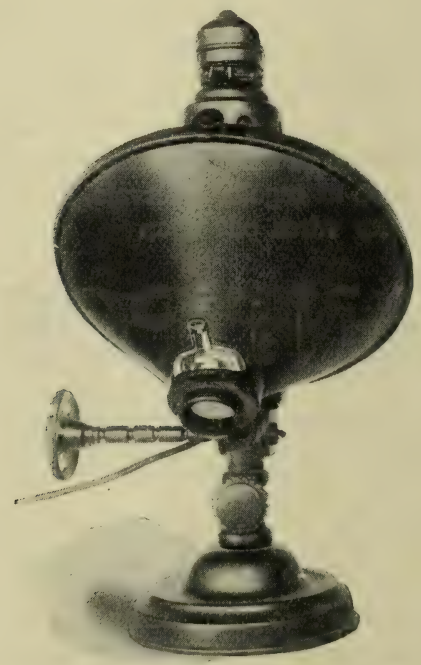

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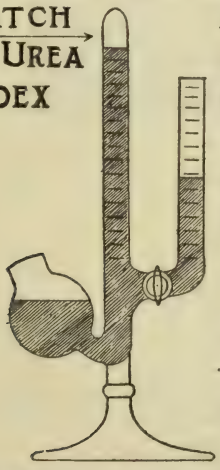

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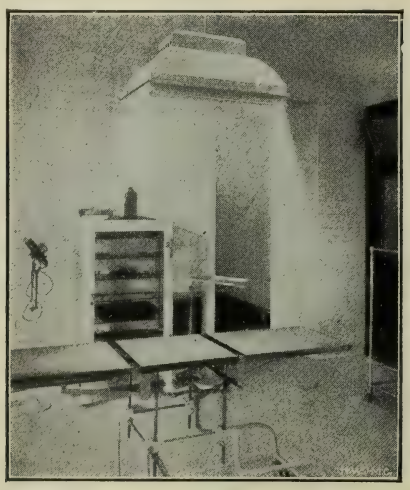

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# Editorial Comment.

## TEXAS GOES FOOT—DEFEAT OF THE VASECTOMY BILL.

*Texas Medical Journal.*

THE Texas Senate, on March 29, by a vote of 14 to 11, six absent or paired, killed the Parker bill for the sterilization of the defectives in the State institutions.

It was not through opposition to the bill, but because of ignorance of it.

It is most remarkable that some of those sent here, supposedly representing the intelligence and honesty of their constituency, should not only fail to make themselves acquainted with the provisions of this, the most important politico-economic and humanitarian reform measure of the century, but that they should, by reason of that neglect, misrepresent it before the Senate and put it in a false light, thus defeating it. They read into it, as Judge White of the United States Supreme Court did into the celebrated anti-trust case, something that was not in it, something entirely foreign to its aims, something which appealed to the prejudices of the average member. To be specific, Senator Morrow opened the opposition by declaring that the proposed operation was "cruel and unusual punishment," and, therefore, unconstitutional, and he made his play entirely on this one thing. If he had even read the bill he would have seen that the little operation is not proposed as a *punishment* for *anything,* and the word "punishment" does not occur in the bill. If he had been honest and fair he would not have so misrepresented the bill. By his effective misrepresentation he has sanctioned the continued flow of degenerates by hereditary descent from those whose care and maintenance is costing the taxpayers millions yearly, and increasing in a ratio of geometric progression. The Texas State Medical Association and the superintendents of our four asylums have realized the necessity of some effort to arrest this deluge of idiots, imbeciles, lunatics, epileptics and hereditary and confirmed criminals, and have asked for the passage of a bill of the kind. The more enlightened lawmakers in ten or more States have seen the wisdom and necessity of such law, and it is now in operation from California through the West and into New York, New Jersey and Connecticut, and probably by now the more Western States of Michigan, Minnesota and Kansas. Hence I say, *Texas goes foot.*

In the discusion—if I can so dignify the senseless talk of certain Senators—one gentleman drew the pathetic picture of a young couple who had built a nest and looked forward to the laugh of many children; pictured their sadness and sorrow and disappointment because some "board," he said, had sterilized hubby. The idiot! The bill confined the operation to the inmates of the charity institutions and prisons—to the wreckage of humanity—to those whose lives had been wrecked by their ancestors. Did he suppose that "boards" were going about seeking whom they might sterilize? Hubby was most likely sterilized by gonorrheal orchitis.

And Kauffman—the doctor's friend—thought that the confirmed criminals would reform—spontaneously! Well, Kauffman's father and grandfather were preachers, and I suppose he had inherited that blesed hope he had doubtless heard them sing about—the

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lamp and the vile sinner. And a fellow—beg pardon, a Senator—named Westbrook tried to be funny. He said, "The medical fraternity has already usurped" (yes, "usurped," he said) "more public functions than is good for the general welfare," and he attempted some jokes. But here comes in the real burlesque—for the performance was (unintentionally) better than a circus. A big fellow—beg pardon, a Senator—named Brelsford, with a voice like a megaphone, made the hall resound with pleas—almost tearful—for "the God-given right of procreation." He thought the bill immoral and indefensible, and wanted to know if we were going to put mankind on a level with the cattle. He suggested that some day a cure might be found for the ailments and defects for which the breeding of these people was to be prevented—that is, for idiocy, imbecility, epilepsy, feeble-mindedness, lunacy and crime. I'll suggest it to Simon Flexner and recommend a consultation with Mr. Brelsford. He may have something to offer in that line.

Nevertheless, this stupid action killed the bill. It was Carlisle who said that ignorance and stupidity are a stronger force in the world than education and culture. They certainly are, when in power. This means more asylums, jails, poorhouses and reformatories and homes for feeble-minded. But it means more. The next generation is to be burdened by their increase, and so on for ages. We have to care for those already on hand, but it certainly is the part of wisdom, statesmanship and common sense to prevent the increase. Suppose Max Jukes had been sterilized? Record of 1200 of his progeny shows all degenerate.

These fourteen learned (?) Senators killed the bill with their eyes and ears shut to the fact that the insane of Texas are costing the people a million a year, and the criminals as much more. They did this in knowledge of the fact that the asylums are not asking this Legislature for nearly a million more to provide more room for more insane and epileptics, and that the Legislature has just authorized the expenditure of $75,000 for a home for feeble-minded (vetoed by Colquitt), and an issue of $2,000,000 bonds for the penitentiary. Why argue with such men when they shut their eyes to such facts?

It were profitless to enumerate the reasons why such law should be enacted. The defectives are increasing faster than provision can be made for their care. A proposition to avert this increase by a perfectly harmless and humane process would seem to need no argument, but we have with us still some Brother Jaspers who insist that "the sun do move."

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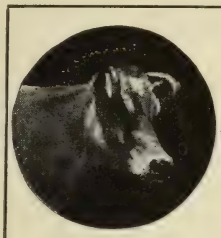
## OPPOSITION TO REPORTING VENEREAL DISEASES.

*Virginia Medical Semi-Monthly.*

That gonorrhea and syphilis should be reported to local boards of health like other reportable diseases continues to be a mooted question, advocates, *pro* and *con*, remaining far apart in their conclusions.

Were it possible for boards of health to secure data relating to all venereal diseases in their respective communities, the good to be accomplished would, beyond question, soon show itself in lessened contagion. Differing, however, from troubles like diphtheria, typhoid and scarlet fever, measles, smallpox, etc., in that



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gonorrhea and syphilis carry reproach in the public eye and mark the possessor with stigma, such sufferers would, in many instances, prefer to manage their own cases in secrecy, resorting to nostrums, etc., rather than put themselves under the care of competent medical attendants, who may be required to report them. Cases of this sort, with no medical supervision, are the ones that will most likely prove dangerous in spreading the disease.

In the few instances where practicable, as, for example, the prostitutes of Norfolk, as also infected enlisted men in the army and navy, compulsory medical inspection and control of individuals affected has proven of great value. But the situation is entirely different in private practice where patients will not willingly submit to having a record of their moral delinquencies registered against them in the office of a public official. A number of States have adopted laws bearing on this subject, the patient's identity being hedged about in some, as in Michigan, where he need not be reported by name, but by office number or other sign. Another State requires a physician's certicate showing a clean bill of health in the male before marriage, but a commentary we noted on this showed the ease with which this law could be negatived.

The whole problem is filled with perplexities, and is yet far from being solved. Possibly a law that protects the patient somewhat after the Michigan method, and at the same time seeks his cooperation, may suggest a way.

Possibly as showing how deep-rooted is opposition to the reporting of venereal diseases, a news item in the *Journal A. M. A.*, for April 5, reports that the Medical Society of the Borough of the Bronx recently entered a protest against an order of the Health Department requiring certain hospitals to record with the Department the names and addresses of all persons suffering from venereal diseases, and if possible the names and addresses of all persons supposed to be the sources of infection. Among reasons assigned are that a knowledge of such cases is confidential and privileged; that such reports may cause blackmail and divorce suits; that statistics will not be improved; that all such diagnoses are not correct, and that prevention will not result from the order, etc.

Surely some of the objections noted from cosmopolitan New York are not without reason in less populous sections of the country.

---

## PELVIC DISEASE IN INSANE WOMEN.

*Ellingwood's Therapeutist.*

In one of the Wisconsin insane hospitals an examination has been made during the last year for pelvic disease in insane women. Dr. Sauthoff of Mendota reports in the *Wisconsin Medical Journal* that in 103 cases grave diseases of the pelvic organs were found, and in the 103 cases there were 250 pathological conditions. A retroverted uterus without adhesions was found in 33 per cent. of the cases. Laceration was found in 27 per cent., arrest of development in 12 per cent., active inflammatory lesions in 54 per cent., cervical tears of any magnitude were found in 16 per cent., and 3½ per cent. of them were pregnant.

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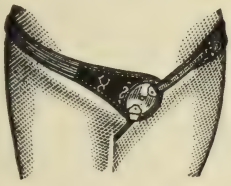

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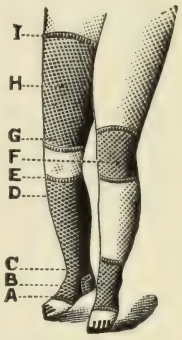


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THE response of general debility, particularly if following an acute disease process, to cod liver oil in a large measure depends upon the form in which the oil is given. As to the power of cod liver oil to supply the tissues with nourishment there can be no question, but as in most of the conditions indicating cod liver oil there is impaired digestive function, it is clearly obvious that unless care be shown in the choice of preparation too great a strain will be thrown upon the gastric powers, with a consequent defeat of purpose. In this connection it should be remembered that while Cord. Ext. Ol. Morrhuae Comp. (Hagee) contains the nourishing elements of the cod liver oil, it is palatable in the highest degree and does not cause the distress following the use of the oil not so treated. Cord. Ext. Ol. Morrhuae Comp. (Hagee) will prove acceptable to delicate stomachs, a feature that makes it of unusual value in debilitated states.

### Vaso-Motor Derangements.

THE part played by the vaso-motor system in countless diseases is at last thoroughly recognized. As a consequence, circulatory disorders are among the most common functional ailments that the modern physician is called upon to correct. Various heart tonics and stimulants are usually employed, but the effect of these is rarely more than temporary. To re-establish a circulatory equilibrium that offers real and substantial relief from the distressing symptoms that call most insistently for treatment requires a systematic building up of the whole body. Experience has shown that no remedy at the command of the profession is more serviceable in this direction than Gray's Glycerine Tonic Comp.

For nearly 20 years this standard tonic has filled an important place in the armamentarium of the country's leading physicians. Its therapeutic efficiency in restoring systemic vitality and thus overcoming functional disorders of the vaso-motor or circulatory system is not the least of the qualities that account for its widespread use. The results, however, that can be accomplished in many cases of cardiac weakness have led many physicians to employ it almost as a routine remedy at the first sign of an embarrassed or flagging circulation.

### The Relief of Rheumatic Pain.

FOR local pain, rheumatism, lumbago, gout, or no matter what may be the etiology, I have been particularly pleased and rarely failed to give relief with Colchi-Sal internally, and Betul-Ol externally applied.

One case which came under my observation in the hospital shows the efficacy of the cutaneous method of absorbing the salicylates, and is worthy of record. A bartender whose right hand and fingers were swollen to double their normal size and so painful that he was incapacitated was treated by massage and local application of Betul-Ol. The following day when I saw the case the pain had entirely gone, the swelling was very much reduced, and in three days he was entirely free from any symptoms. Patient was much astonished by such speedy relief.

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---

**The New Treatment for Gonorrheal Infections.**

PHYSICIANS who have had any considerable experience in the treatment of gonorrhea and its complications know how stubborn many of these cases are; how, not infrequently, they resist ordinary routine methods for weeks and months. The average general practitioner encounters these cases with unpleasant forebodings. He realizes that treatment of them is more or less empirical. He experiences a sense of relief when he can bid "good-bye" to one of them—when he can discharge it as "cured."

For the reasons enumerated, any new therapeutic agent which promises a fair percentage of recoveries in gonorrhea and its sequelæ is certain to be accorded a warm reception by the medical profession.

Is Gonorrhea Phylacogen such an agent? There is a basis for the belief that it is. Here are some figures that seem to lend assurance: "Six hundred and sixty cases treated—539 recoveries, 121 failures." These figures pertain to carefully-recorded cases, under observation in various sections of the United States and embracing both hospital and private practice. They include such complications as gonorrheal arthritis, chronic urethritis, vaginitis, epididymitis, orchitis, prostatitis, vesiculitis, ophthalmitis, iritis, endometritis and salpingitis. These cases were reported to Messrs. Parke, Davis & Co., producers of the Schafer Phylacogens. The results point clearly to this conclusion: Gonorrhea Phylacogen is worthy of careful, serious consideration.

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**The Therapy of Neurotic States.**

THE bromides have served no more useful purpose than in those unstable nervous states so frequently met with in women, and yet, owing to this very instability, their administration must be supervised with the greatest care if the patient is to be guarded from the disadvantages which accompany the use of these salts.

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**Typhoid Fever.**

IN a large majority of cases of typhoid fever there is undoubtedly an intestinal lesion, but other organs are also affected. In a few cases post-mortem examination reveals no lesion whatsoever in the alimentary tract. Typhoid fever differs from some of the infectious diseases, in that during its course the entire body is exposed to a specific bacillus, and that the lesions are, therefore, really several-fold. Many physicians do not admit this fact, and speak of and treat enteric fever as if it were an infection confined to the intestinal canal. In typhoid fever, on the other hand, the patient may be seriously sick with a non-enteric typhoid and yet have an intestine totally free from the typhoid bacilli and from any of the

intestinal lesions of the disease. The reports from pathologists show that many cases are now on record in which typhoid fever was present, and in which no intestinal lesion was found. If the disease is an infection involving various organs of the economy, the treatment which only has in view the lesions found in the intestinal canal will be inadequate to meet successfully the patient's condition; consequently a close and careful study should be made of any suggestive cause.

In the treatment of typhoid fever the patient should be in an aseptic, well-ventilated, light and cheerful room. He should have water at stated intervals. It is a great mistake to neglect this, as when a patient is unconscious he should have water and, of course, does not then ask for it.

The medical treatment of enteric fever is largely symptomatic, the patient suffering from the infection produced by the typhoid bacillus. The body is necessarily affected by splenic toxemia; the intestinal glands and other organs are involved. Prominent among the latter symptoms are emaciation and malnutrition, and this should be combated by a food which will not overtax the digestive system, and will at the same time supply every element of nutrition. Bovinine is ideally indicated as a food. From the onset antiseptics are indicated, and should be administered more or less throughout the entire course of the disease; but, most of all, keep the patient's temperature down by sponge baths, and the strength and nutrition as near normal as possible.

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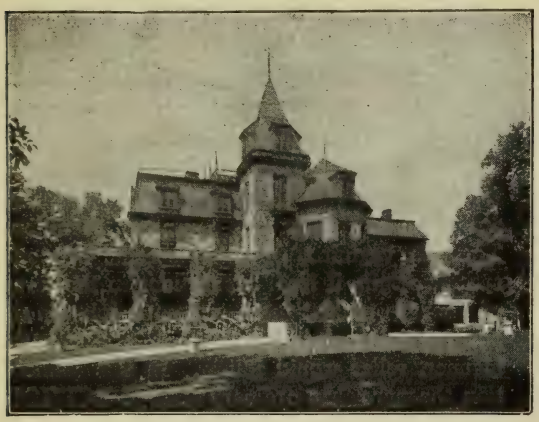

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# Editorial Comment.

## THE ARMY CANTEEN.

*Texas Medical Journal.*

Dr. Maus, chief surgeon of the Eastern Division of the United States Army, publishes an exceedingly interesting article in the *New York Medical Record* for February 22, 1913, in which he supports, from official data, his refutation of the charges that abolition of the army canteen, made by the pro-canteenists, has increased sickness, inefficiency, drunkenness, desertions, diseases, insubordination and vice in the army, and has multiplied the number of saloons and brothels contiguous to army posts.

Dr. Maus quotes from the surgeon-general that "statistics do not show that absence of beer from the canteens has increased the admissions to sick reports or the ratio of constantly sick," and claims that the report of that functionary for 1912 discloses the fact that the health of the army was never better; that the ratio for sickness for 1911 was 7.6944 per 1000, and 7.6606 for 1910, the lowest ratio in the history of the army, while during the canteen period it was 10.90 per 1000, with a yearly average of 12.46, and that during the period of a beerless canteen the non-efficiency of the army has been 33 per 1000, and 42 during the flourishing days of beer-drinking canteens. The admission rates due to alcoholism during the beer-drinking period was 46 per 1000, and only 20 since its abolition, while desertions have steadily decreased in proportion, until it was actually less in 1911 than at any time during the last ninety years, and he challenges anyone to truthfully refute these facts and figures.

Concerning diseases due to vice, Dr. Maus, with an experience of nearly forty years, claims that prior to 1901 but little attention was paid to diseases from this source, and that 60 per cent., at least, of soldiers thus afflicted received no official attention, and that the records during the canteen period bearing on this phase of the subject are extremely faulty and incomplete, but, judging from his own large experience and that of very many of his fellow-surgeons, he believes they are less than at any time during the canteen period, and that if the recorded rate of such diseases during the time of the beer canteens, that of 75 to 85 per 1000, was multiplied by three it would be much nearer the actual figures, and that it would give a rate of from 225 to 250 per 1000, as against the present rate of 163. During the canteen period, in 1890, the rate at Columbus Barracks, Ohio, was 462 per 1000, and at many other posts during that year it was as high as 250 per 1000.

Dr. Maus claims that hundreds of cases of syphilis carried on the sick reports of today were contracted prior to enlistment and were disclosed only by the Wassermann reaction, and quotes Major Howard of Jefferson Barracks, Missouri, that 50 per cent. of venereal cases treated at that point were ante-enlistment infections. Jefferson Barracks is one of the principal recruiting stations, through which thousands of recruits yearly pass.

Maus denies that abolition of the canteen has multiplied the number of saloons near army posts, and cites Fort Sam Houston, Fort Hamilton, Fort Wingate, Brooklyn, New Mexico, etc., where every street surrounding the posts contained saloons. He regards the beer canteen as a kindergarten for the young recruits and

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training school for the alcoholic habit, where hundreds of the bravest and best officers and men are cut down and rendered unfit in the prime of life, many being forced to drink to escape the gibes and jeers of their companions.

Beer drinking has the same effects, morally and physically, upon the American soldier that it has upon the American civilian, and produces the same pathological conditions that are produced by other alcoholic beverages, but excites the venereal appetite more than the others excite it. Hence it is that a few glasses of beer at the army canteen, a few more in nearby saloons, the soldier's animal instincts are aroused, and he at once marches direct to the red light district—sometimes as far as six miles away—where he is often drugged, robbed, infected and oftentimes murdered outright—facts which are well known to the War Department as they are to the few braided and buckled officials who, with their wives and some equally misguided civilians, are clamoring for the Government to restore this prolific source of inefficiency, prostitution, disease, death and perdition, as a constant temptation to the men on whom the nation must rely in time of danger, and that, too, in face of the fact that manufacturers, merchants, bankers, farmers, civic and public-utility corporations and even liquor dealers themselves are barring from employment men upon whom the drink habit has impressed even its slightest imprint. No one, be he soldier or civilian, matron or virgin, young or old, whose system is daily polluted with alcohol, even in minute quantities, is in a normal condition, and *pari pasu,* with increase in the quantity ingested does such an one become less normal and less capable.

## PREGNANCY WITHOUT MENSTRUATION.

*Ellingwood's Therapeutist.*

Two reports have been made of patients, sisters, both of whom had several children, with no appearance at any time of menstruation. This editor knew of a woman who hesitated about marrying because she had never menstruated, although in perfect health. After marrying she gave birth to several children, retaining all the time superb health, and never during her child-bearing period did she show any sign of menstruation. There is no doubt there are other cases, if reports were made or accessible.

## FRIEDMANN AND HIS "CURE."

*The St. Paul Medical Journal.*

THERE is probably not another country on the face of the earth where such an occurrence could take place as the recent spectacular arrival at the Waldorf, in New York, of Dr. Friedmann of Berlin with his much-heralded "cure for tuberculosis." There is, perhaps, no science except medicine concerning which a single individual can by means of a clever press agent successfully foist upon a large element of the public an alleged discovery, and make them for a long time believe it to be true. To be sure, Dr. Frederick Cook accomplished something of the sort when he claimed to have discovered the North Pole, but his fake was short-lived, and while he managed to get a comparatively small amount of money out of it, it was not obtained at the expense of the cruel suffering and the many heartaches which are sure to result from the preposterous claims of Dr. Friedmann. Does anyone think

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for a minute that if Dr. Friedmann had really discovered a cure for tuberculosis it would have been necessary for him to leave Germany to exploit it, or to receive the glory and the pecuniary rewards which would have been sure to come to him there? Either Dr. Friedmann or his managers were shrewd enough to know that America, the land of the foolish free, was the place for him to make money out of his "cure," and money in vast amounts he will undoubtedly make before the stern test of the laboratory and the clinic can show the falsity of his claims. We are not much concerned about the money he may filch from the rich, for they can afford to pay for their folly, but the aftermath of sorrow and bitterness that must come to the vast army of the middle class and poor victims of tuberculosis, many of whom will undoubtedly make most tremendous sacrifices to furnish their loved ones with the means of taking this new and wonderful treatment, is enough to make our hearts bleed. When will the world learn that an actual new discovery of real value in the treatment of disease cannot remain in the hands of one individual, but will speedily be the property of the whole medical profession, and that the only persons competent to judge of the efficacy of a new method of treatment are those physicians who have special knowledge of the particular disease under consideration?

Now, who is this Dr. Friedmann? and what is it that he has discovered? Dr. Franz F. Friedmann is a comparatively young bacteriologist, who has never been a practicing physician, but has always been a laboratory man. He claims to have discovered that a certain type of tubercle bacillus (exactly how obtained he has never stated) after having passed through a certain phase of its existence in the turtle becomes avirulent for human beings, and that its introduction into the human body confers an immunity against tuberculosis, and that it also cures the disease if already present. A careful and critical examination of his published papers shows a pitiful lack of both experimental and clinical proof of his claims, and, furthermore, his attitude from the beginning of his work has been distinctly commercial rather than scientific. Having been thoroughly discredited in his own country, he has come to America accompanied by a clever press agent, and is now seeking to exploit himself and his method of treatment purely for money. How much of the sensational newspaper publication in regard to him and his work has been paid for, and how much has come from the sensational instinct of the "yellow" element of our national press, which is always willing and anxious to disseminate misinformation regarding medicine, will probably never be known. We are confident, however, that scientific demonstration of the falsity of Dr. Friedmann's claims will very soon be made, and in such unmistakable terms that this new meteor which has flashed across the medical horizon will be quickly extinguished, although it will be long before the cruel heart-wounds which must inevitably be left in its wake can be healed. For these the people must blame its newspapers, and not the medical profession.

A good many other laboratory workers have experimented along the same lines as those pursued by Dr. Friedmann, and many believe that the ultimate solution of the tuberculosis problem will come through some such method of treatment, but the demonstration can only be made through a long series of painstaking and scientific laboratory and clinical experiments confirmed by many

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TO

Medical Advertisements

PAGE II

different observers. Thus far such experiments as Dr. Friedmann has made have been unsatisfactory and absolutely inconclusive, consequently they have not been accepted by the scientific men of his own country, nor will they be by the scientific men of this country. In Germany the people are not so easily duped as are Americans, and the German newspapers do not accept an unsubstantiated claim concerning a new method of treatment as a truth, and announce it as such, as our newspapers do. Hence America is the ideal country for such an exploitation as Dr. Friedmann is making, and is perhaps the only country where it could be profitably carried out. We hope, however, that the exact truth regarding Dr. Friedmann's method of treatment will be made known before many months, and that the people will profit by the lesson which it will teach.

---

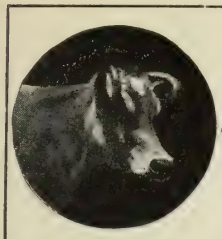
## HONORS TO THREE SOUTHERN MEDICAL COLLEGES

At a recent meeting of the Association of American Medical Colleges, held at Chicago, the Schools of Medicine of the Universities of Alabama, Georgia and Texas were admitted to full membership.

Though somber minds may consider fame as but the fickle breath of the thoughtless crowd, yet there are worldly honors worth the winning, their carping comments notwithstanding. The man who strives to merit and win the approval of his fellows, and glories in their praise, is every whit as sensible as those who pretend to be immune to such influences. Moreover, the world, in seeking for the best instruments to do its work, must either choose them blindly or be guided by the verdicts of observers who have opportunity to judge aright. Especially is this true of institutions of learning to which the world consigns its precious treasure, its plastic youths, who are by them to be moulded into the future owners of the earth and all that is therein. Only by the verdict of experience and qualified observation can one know the good from the bad, the real from the pretended.

In these United States of America the medical profession has established for the protection of themselves and their worthy fellow citizens against deception by fallacious boosting, two supreme arbiters of character in medical colleges. One is the A. M. A. Council on Medical Education, the other is the Association of American Medical Colleges. Whatever school proves satisfactory after rigid examinations and repeated investigations by personal agents of the Council is assigned to class A, and thus proclaimed able and worthy as an institution for teaching modern medicine. Having won this honor, a school of medicine may, if it so desires, apply for membership in the Association of American Medical Colleges, in which case inspectors are sent to look carefully into all the details and work of the institution, its equipment and support, and if these are approved it is received into the association, crowned with the double honor that expresses the highest reward attainable. There is nothing higher. All beyond is a matter of expansion, of numbers, of increased equipment and income, but not of degree.

Such is the honor that has come to the schools of medicine of Alabama, Georgia and Texas. Only absolute merit could win it. Wealth, numbers, political pull alike are powerless to open



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the gates of admission to this association, and only class A colleges can enter.

The people of Alabama, Georgia and Texas owe gratitude to their universities for bringing them such signal honor. No longer need they send their young men to other States to study medicine because other schools are better, for they are not. The years that are spent in earning the degree of M. D. should be passed in their own universities. There is no longer an excuse for sending them elsewhere. To do so is to insult their State and lapse from loyalty. Then honor and patronize your own colleges that have won recognition from the highest arbiters in your country.

## THE SANITARY PRIVY A SUCCESS.

*Southern Medical Journal.*

READERS of this *Journal* have several times been urged to favor the establishment of so-called sanitary privies wherever sewerage was not available. A recent percentage of the health officers of Wilmington, N. C., demonstrates the effectiveness of that principle in preventing a threatened spread of typhoid fever.

In that city there has been for a number of years an average number of 200 cases annually. The greatest frequency of cases was invariably during the time of year when flies are most abundant. A new health department in Wilmington took hold of affairs on June 1, 1911. At that time there was an epidemic of typhoid, which was rapidly spreading. The officers supplied infected families with water-tight steel cans of disinfecting fluid. A similar can was furnished, when needed, to receive the disinfected secretions. This can was kept in an outbuilding screened from flies, and emptied and cleaned by the city without cost to the citizens. It was the screened, sanitary privy in principle, and was a substitute for them where they could not be installed. As a result only about sixty cases occurred during the months of May, June, July, August and September, 1912, when during the same months of 1911 there were 250 cases. The chief health officer, or superintendent, Dr. Charles T. Nesbitt, thinks there must be a large number of typhoid carriers in Wilmington, and as there are some 3000 surface privies in the city, the question of screening and sanitary management is very important.

## BUTTERMILK AS A FOOD.

*Ellingwood's Therapeutist.*

THERE is no doubt that buttermilk is a very important food, and the probabilities are that to one who has been overeating and finds it necessary to relieve the stomach for a time, the use of buttermilk will satisfy the hunger thoroughly for several days, and accomplish all the results of a complete fast.

But buttermilk made by artificial processes is by no means as satisfactory as that made by the usual churning process. A writer in the *J. A. M. A.* says that there are small glass churns on the market that will hold from one to four quarts, and if one would take whole milk, allow it to sour and thicken in a warm room for twenty-four hours, and then churn it in one of these little churns from five to eight minutes, he will have, after removing the small amount of butter that accumulates, a perfect specimen of natural buttermilk, which is palatable and much superior to the artificial product.

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can be disinfected and deodorized by placing in a tub half filled with boiling water to which has been added a little "Platt's Chlorides." The tub should then be closely covered for two hours and the clothes thoroughly rinsed before washing.

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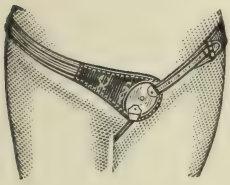

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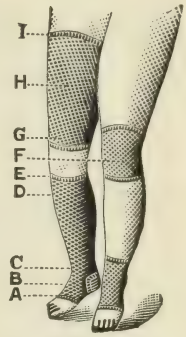


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### Danger Due to Substitution.

HARDLY another of all the preparations in existence offers a wider scope to imposition under the plea of "just as good" than the scientifically standardized Eucalyptol.

The most recent fraud practiced in regard to this product is an attempt to profit by the renown of the firm of Sander & Sons. In order to foist upon the unwary a crude oil, that had proved injurious upon application, the firm name of Sander & Sons is illicitly appropriated, the make-up of their goods imitated, and finally the medical reports commenting on the merits of their excellent preparation are made use of to give the desired luster to the intended deceit.

This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

### Hormonal.

IN 1908, Zuelzer and his collaborators discovered that in the normal body economy of human beings and the higher animals, intestinal peristalsis is produced by and dependent upon an internal secretion of the gastric mucous membrane which is elaborated at the height of the digestive process and stored in the spleen. A suitable process for the aseptic extraction of this "peristaltic hormone" from the spleen having been devised through animal experimentation, followed by extensive clinical study, demonstrated that when introduced into the blood stream this substance vigorously stimulates the weakened peristaltic function in the atonic intestine and is actually able to revive it when practically extinct in paretic conditions.

Early in 1911, after three years of experimentation, the Schering Chemical Works placed the preparation upon the market under the name of Hormonal as a specific treatment in certain forms of chronic constipation, intestinal atony, but above all in those distressing cases of post-operative paresis of the intestine which absolutely fail to yield to ordinary medical or mechanical therapeutic measures. For the former class of cases, the intramuscular form of administration was recommended; for the latter, the intravenous. Later on it was found that the intravenous

medication should be given preference whenever practicable and that in some cases the adult dose, originally given at 20 cc., could advantageously be raised to 30 and even 40 cc.

In view of the extreme gravity of the surgical cases, in which the preparation is indicated, the results (about 60 per cent. positive) were nothing short of remarkable. In the medical cases, the somewhat lower percentage of positive results (about 45 per cent.) may in part be explained by the recognized difficulty of making a clear differential diagnosis between purely atonic and purely spastic types of constipation, and by the employment of the preparation in the latter class of cases or even in constipation due entirely to mechanical causes, though explicitly disadvised in the introductory literature.

All clinical investigators concurred in the statement that beyond a transient rise in temperature, slight headache, occasional nausea and—in the intramuscular administration—more or less local pain, all of which disappear promptly, no untoward by-effects of the treatment could be observed. Anaphylactic phenomena were not reported and the possibility of their occurrence still further decreased by the *complete elimination of albumin.*

Hormonal had thus been on the market for more than 12 months, having been administered in approximately 11,000 cases (of which about 3,500 received intravenous injections), when suddenly and in rapid succession several cases were reported in which the intravenous injection of the preparation was stated to have been followed by severe collapse. After due elimination of air-embolism, anaphylactic shock, etc., as a possible cause for the same, it was ascribed to a powerful blood-pressure depressant action alleged to be characteristic to the normal physiologic action of the preparation, and the employment of the latter represented in various medical journals as fraught with danger. On page 4 we have given a complete up-to-date list of publications on Hormonal, favorable and unfavorable alike. Those which contain reports of untoward by-effects are marked with an asterisk (*). Each report represents *one single case,* 10 *cases in all,* being *one-twelfth of* 1 *per cent.* of the total number of cases recorded and *one-quarter of* 1 *per cent.* of those which received the intravenous injection. Of the remaining large number of reports one only describes a single case, all other contributors basing their conclusions on from 2 *to* 75 *observations.*

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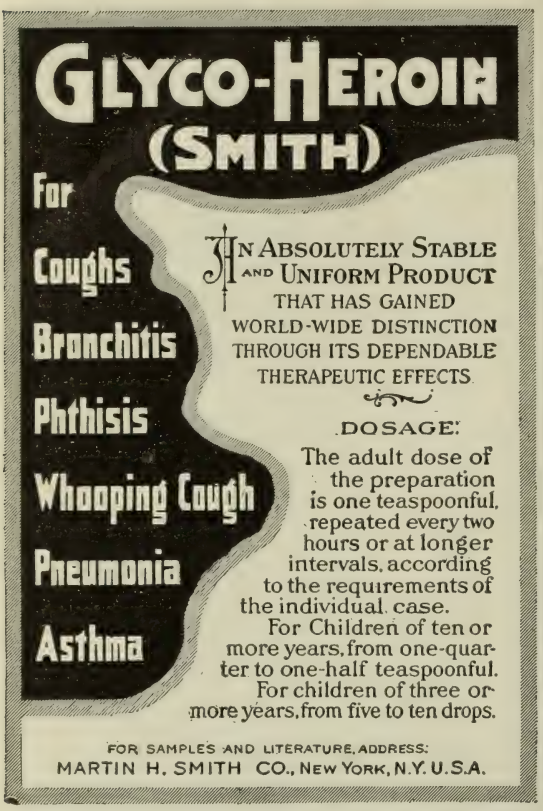
An extensive investigation by Zuelzer revealed the presence in varying quantities of an albumose as one of the causes of this sporadically observed forcible blood-pressure reducing action. All Hormonal placed on the market since July, 1912, (older material having been withdrawn) *is rendered practically albumose free, each batch being submitted to rigorous physiologic and clinical tests by Dr. Zuelzer personally, before leaving the Schering Chemical Works.*

Under proper technique of administration, this preparation has been definitely demonstrated to exercise in the vast majority of cases only a minimal fluctuation in the blood-pressure which is of very short duration and represents a part of the normal physiologic action of Hormonal, the latter being accompanied by a strong flow of blood to the intestine.

It is, however, more than probable the failure to observe certain fundamental precautions in the technique which is to the largest extent responsible not only for the occasional occurrence of disquieting by-effects, but frequently also for negative and inadequate therapeutic results from Hormonal therapy. Recent very thorough and successful clinical work with the preparation in Greater New York hospitals furnish striking proof of the efficiency and safety of Hormonal if administered as follows:

*Intravenously*—Advised for hospital use only. Dose, 22 cc. The liquid is first warmed by immersing the bottle in water of about 110° Fahr. and held as nearly as possible at body temperature during the injection, which is made drop by drop into the median vein, allowing 15 to 20 minutes for the entire 20 cc. to enter.

*Intramuscularly*—Dose, 20 to 40 cc. The liquid is warmed to body temperature and the injection made deep into the gluteal musculature, one-half of the dose on each side. Two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to four hours later one or two tablespoonfuls of castor oil should be given to assist in the dislodgment of impacted fecal masses from the large intestine.

The administration of opiates shortly before and after Hormonal injections must be avoided, as they counteract the physiologic action of the latter.

---

**Heart Weakness.**

HARDLY any of the patients who consult the general practitioner give him more worry and trouble than those who come to him complaining of "heart weakness." Careful examination, while disclosing no organic lesion, almost always shows varying degrees of functional disturbance. Palpitation, arrhymia, precordial pain, dyspnea, and a wide variety of other symptoms are present most of the time to keep the patient in a state of constant apprehension.

How difficult it usually is to give these heart sufferers complete and permanent relief is only too well known by physicians who are constantly meeting such cases. Obviously, at the very outset, it is essential to remove all contributory causes as completely as possible. The digestive and eliminative functions call for appropriate treatment, and especial attention should be directed to the diet. Bad habits, such as excessive indulgence in alcoholic beverages, tea, coffee, tobacco or narcotic drugs must be corrected and a patient's whole manner of living placed on as nearly normal basis as possible.

For the heart itself, a mild tonic is needed, one that will act as a bracer and at the same time regulate its action. Cactina Pillets meet this need most acceptably, and the results that promptly follow its administration readily account for its widespread popularity as a safe and dependable cardiac tonic. Under its use the palpitation and irregular action so uniformly complained of by those with functional heart disorders are soon corrected. Cardiac pain and other subjective symptoms are likewise removed, and as the heart's action is restored to its normal frequency and rhythm, the patient's worries and fears rapidly disappear.

Cactina Pillets are especially serviceable for correcting the functional weakness or derangement that often attends the use of tobacco—the tobacco heart—and the whole train of startling symptoms—tachycardia, irregularity, sudden faintness, precordial pain, etc., are overcome with a promptness that is always exceedingly gratifying to the patient.

Unlike many heart remedies, Cactina Pillets can be administered without the slightest fear of cumulative effect. It has no contra-indications, moreover, and clinical experience has conclusively shown that it can be used under any and all conditions with implicit confidence, not only in its freedom from harmful or unpleasant effects, but equally in its capacity to accomplish marked and far-reaching benefits.

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**Mixed Bromides Desirable.**

THE reliability, as a sedative, of Peacock's Bromides is based upon the fact that only pure salts are employed in this compound, and each of its five bromides enhances the action of the others. The most frequently-used bromide has long been the potassium salt, although it is well known to be somewhat depressing to the heart and injurious to the stomach in cases where its use is deemed necessary for a considerable length of time. This may be almost entirely avoided by administering it as combined in Peacock's Bromides, a preparation which assures the highest possible de-

gree of therapeutic action with the least possible tendency toward "bromism"; hence the doctor may feel confident in prescribing Peacock's Bromides that is he ordering only the purest salts and getting 15 grains to the dram of the desirable combination of Ammonium, Calcium, Lithium, Potassium and Sodium Bromides—in a most delightful elixir. This vehicle effectively covers the natural acridness of the bromides, and proves highly satisfactory to the patient. By ordering the original eight-ounce bottle from his druggist, the careful physician will ensure his patient getting the five salts in purest, pleasantest form.

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**The Hypersusceptibility of Children to Opium.**

THE hypersusceptibility of children to opium is one of the most potent reasons for employing a substitute in its place in the treatment of diseases of children. It has been found that Papine (Battle) is well borne by children to whom opium or morphine was intolerable, but when it is remembered that in the manufacture of Papine, through a special process, the narcotic and convulsive elements of opium have been eliminated, the reason for this point of Papine's superiority over opium will be well understood.

Papine (Battle), as is well known, is a product of opium subjected to a process which, while retaining the analgesic and sedative properties of the drug, separates from it its objectionable qualities, leaving the finished product of more than ordinary worth as an opiate for use in children.

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**Why Anusol Suppositories Maintain Their Absolute Supremacy Amongst Rectal Remedies.**

ANUSOL SUPPOSITORIES have for nearly a decade and a half maintained their world-wide reputation among the medical profession as the most effective, the safest for the patient (in the end), the most economical and for the physician the most credit-bringing of all topical rectal remedies.

*The most effective,* because they unite in unequalled completeness all the prerequisites of correct and successful rectal medication, affording simultaneously the maximum anodyne, stool-softening (strain-relieving), antiseptic, astringent (decongestive), desiccant, granulating, healing and tonic action.

*The safest,* because they are absolutely free from narcotic, caustic or other toxic ingredients; therefore, may unhesitatingly be used in both sexes, from infancy to old age and in the presence of every possible local or systemic complication.

*The most economical,* because their deservedly somewhat higher price is negligible, in view of the fact that they achieve the most thorough and lasting results in the reasonably shortest space of time.

*The most credit-bringing,* because they seldom fail to meet the exigencies of cases which have resisted all other forms of medication, and very frequently entirely obviate surgical intervention where, before their employment, it positively seemed to be the last resort.

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**Soporific Power Without Evil Effect.**

INASMUCH as all too many excellent soporific agents unfortunately produce evil effects in connection with their tranquillizing influence, the exceptional value of one which is free from bad qualities will be readily appreciated by all practitioners. It is this appreciation of therapeutic merit which has brought Pasadyne (Daniel) into such wide use in relief of sleeplessness, nervous irritability, and even pain. As is well known, Pasadyne is the Concentrated Tincture of Passiflora Incarnata, the advantages of which have been known by a large part of the profession for many years. By employing Pasadyne (Daniel), one may secure full soporific power without distressing after-effects.

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# Abstract.

## WOOD-ALCOHOL BLINDNESS.

H. Woods, Baltimore (*J. A. M. A.*, June 7), reports two cases of blindness from wood alcohol in addition to those formerly reported by him. His object in reporting them is to arouse, if possible, a sufficient medical public opinion to bring about legislation that will protect unsuspecting individuals from misfortune from this source. In one of the cases the blindness is attributed to the external use of wood alcohol; in another from drinking supposed and mislabeled whiskey containing it. The cheapness of the substance is a temptation to manufacturers and dealers, and the discovery that it could be deprived of its nauseating qualities has been a misfortune. He remarks on the singular fact of the different susceptibility of individuals, some persons seeming to be able to take considerable quantities with immunity. The preventive methods Woods recommends, in case its manufacture cannot be prohibited, are, first, making it mandatory to leave it undeprived of its nauseous qualities or else making it otherwise unfit for drinking. The State Board of Health should control its use, and individuals, firms or corporations utilizing it should be obliged to report the fact to the Health Board. Its use in vaults, vats or unventilated places is a terrible menace to society and life, and should be regulated. Those using it should take special pains to instruct their employes as to its dangers, and wherever it is sold it should be with the usual precautions attending the sale of dangerous poisons.

# Editorial Comment.

## HOOKWORM CAMPAIGN IN ALABAMA.

*Southern Medical Journal.*

Dr. Wm. H. Sanders, State Health Officer; Dr. William W. Dinsmore, State Director of the Hookworm Campaign, and three assistant directors, viz., Dr. T. Frazer Orr, Dr. W. W. Perdue and Dr. E. V. Caldwell, constitute the executive and field force actively engaged in the work. The ability of an executive officer is chiefly displayed in his selection of subordinates, and their fitness is demonstrated by the degree of success they attain. In this instance the results have been, so far as the effort has been extended, all that could be desired.

The plan is to secure first the approval and co-operation of the county medical societies where the work is to be done, and then the assistance of the county officials. Money is the test of sympathy, and in this instance the money has been appropriated when asked for. In the fourteen counties covered at the time the *Journal* received its information, not one county court of commissioners has failed to respond favorably to the petition from the directors for funds with which to fight the hookworm. This is because of the previous education concerning the parasite, due primarily to Dr. Charles Wardell Stiles and his persistent work, and next the energy and talent displayed by Dr. Dinsmore, who has accom-

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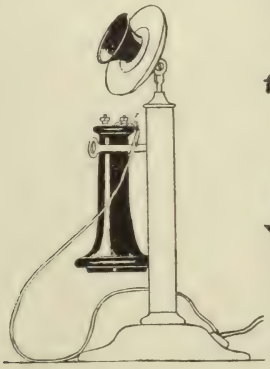

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plished immense improvements in the territory which he has thus far been enabled to cover with the aid of his able assistants. He has distributed numerous leaflets of a practical character that must have great effect in educating the people of infected localities.

Under the direction of Dr. Dinsmore and his assistants the effort has been thoroughly systematized. Children from six to eighteen years of age have been inspected in and out of school and taught the nature of the danger of soil pollution; lectures illustrated by lantern slides have entertained and convinced the parents and other "grown-ups;" free dispensaries for diagnosis and treatment of hookworm have been established at convenient points in the counties worked, and it has in every way possible been made easy for sufferers to find relief and restoration to health. In all these matters Dr. Dinsmore and his official assistants have been constantly active and successful. Under his direction the pioneer worker in the counties was Dr. H. G. Perry, who, with Dr. T. Frazer Orr, opened the campaign in Houston county. Dr. Orr established a dispensary at Dothan, while Dr. Perry extended the work to adjoining counties.

Alabama will owe Dr. Dinsmore and his co-workers a debt that no mere money reward can repay when her infected, languid citizens have been restored to their full life and vigor, able and ready to perform their duty to humanity and the State. It is almost like witnessing a resurrection to see whole neighborhoods that had been marked by apparent indolence and inefficiency suddenly springing forward to seize the tools of industry and the opportunities for improvement. Nothing exactly like the modern crusade against hookworm has ever before been witnessed in the history of humanity, and future generations will honor the memory of Stiles and his followers, among whom the name of Dinsmore will brightly shine.

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## CRIMINAL ABORTION.

*Ellingwood's Therapeutist.*

NOTWITHSTANDING a prominent New York editor has within the past year written a large number of articles which can readily be construed to favor production of abortion, some pointed articles have been recently written by excellent writers showing the terrible effects of criminal abortion. A German writer recently claims it is a source of depopulation, surpassing in importance that of epidemic diseases. He claims that the conscience of the public should be trained to deprecate such a truly criminal procedure.

---

## "LOCOED" AGAIN.

*The Medical Standard.*

MODERN science has a way of astounding us with startling "discoveries" which upset all our settled ideas. But too often, after we have oriented ourselves to the new idea, someone comes along and makes a new investigation—and science takes it all back!

Such has been the experience with "loco" disease, as it is called, which annually destroys some millions of dollars' worth of stock in the Western States. Four years ago Crawford of the Government Bureau of Plant Industry made a study of loco weeds, and

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came to the conclusion (which seemed to be well supported by evidence) that this disease was caused by the presence of barium or its salts in these plants. It was supposed that the barium had a peculiar toxicity for animals eating plants containing it.

However, the work of Alsberg and Black (Bulletin 246, Bureau of Plant Industry), recently published, leaves us just about where we were four years ago. They have found that other plants in the Western States contain about as much barium as the loco weeds, but do not injure stock on the range. Moreover, the barium in the loco weeds is present in an almost insoluble form; and still further, there are enough salts of calcium, potassium and other metals contained in the loco to kill the experimental rabbits when these salts are extracted; but similar extracts of alfalfa will also kill the rabbits if given in the same dosage.

The barium theory of loco disease is, so it would seem, pretty well exploded. Thus passeth another of our "triumphs of modern science." In passing we might remark that we have seen theory after theory, in all branches of science, come and go in the same way. But we go forward constantly just the same.

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## THE RAT, THE FLEA AND THE PLAGUE.

*Southern Medical Journal.*

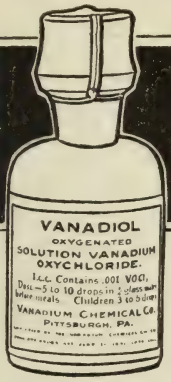
UNDER the above title Dr. Isadore Dyer of New Orleans publishes a pamphlet under the auspices of the New Orleans Medical Plague Conference Committee, composed of the health officials and the leading physicians of that city.

The theme of the pamphlet, printed in capital letters is, "No Rats, No Plague. The rat is the carrier, the flea is the transmitter. Plague, rat, flea, man; plague, rat, flea, man, so the cycle runs." Abolish either rats or fleas and you abolish the plague. In view of such a simple problem it would seem amazing that so many millions of human beings have been destroyed by plague since recorded history began. But, unfortunately, the bacillus pestis can be communicated by other means than the simple cycle described.

There is no doubt of the efficiency of rats and fleas in transmitting plague, but when once established plague can be transmitted from one person to another by the breath, causing the pneumonic form, which is the most fatal of all. However, if the rat and the flea did not first get in their work there would be no deadly effluvia for inhalation from an infected breath.

Dr. Dyer cites the example of San Francisco in the second plague invasion, that of 1907, when the citizens had learned by costly experience the folly of concealment and the wisdom of prompt and public action. When all classes and conditions of people went to work together intelligently and energetically, the disease was conquered and commerce revived.

Nearly a year ago the *Southern Medical Journal* editorially warned its readers of the inevitable danger now so apparent. Like "the voice of one crying in the wilderness," the warning had little effect, and it may possibly be true that even now some infected rat has burrowed in the sewers of Southern cities, which are just waking up to their peril. So the *Journal* again enunciates a warning to our Southern coast cities, and it is this: *Lookout for*

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*dead rats.* The finding of *one* such should arouse suspicion, *two* should awaken *fear, three* should provoke a thorough investigation.

*Lookout for dead rats!*

## THE "MOVIES" AND EYESTRAIN.

*The Medical Standard.*

CONSIDERING the enormous growth of the moving-picture business, it is remarkable that there has been so little complaint of injury to the eyes as a result of attendance upon these places of amusement However, Dr. George M. Gould, who is ever on the alert for evidences of eyestrain, reports in the *Journal of the American Medical Association* the rather frequent occurrence of symptoms that can only be ascribed to this cause. These symptoms, he says, do not differ greatly from those commonly caused by eyestrain of any kind. The most common are headache, sick headache, migraine—in one of its many protean forms. There may be also ocular or cerebral weariness, malaise, loss of appetite, "sick stomach," even vomiting, sleepiness, and the common complaint that "my glasses need changing." Dr. Gould seems to believe that the eye disturbance by the moving picture is due to causes that in part, at least, are removable. When the pictures are illuminated better than they now are, and the pictures are so rapidly photographed upon the films that there is complete continuity of scene, instead of the rapid, yet still perfectible, hiatus between the different images, they will be much less likely to put dangerous strain upon the human retina. Considering the rapidity with which the kinematograph business has grown up (there are now from 12,000 to 20,000 moving-picture theaters), it is not to be wondered that the technical problems are still far from being solved.

## THE THYROID IN CONVULSIONS.

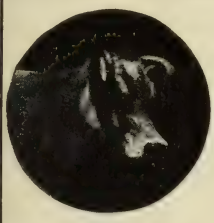
*Ellingwood's Therapeutist.*

NOT only in puerperal convulsions, but in epilepsy, has the use of the thyroid extract recently been found to be beneficial. A foreign writer has used .5 gm. thyroid extract daily, with improvement in the attacks almost from the first, and a gain in the mental condition. We must learn to designate between those cases in which this extract will be beneficial and those in which it will be undesirable. In inefficient action of the thyroid it should be a desirable remedy.

## A FIVE YEARS' MEDICAL COURSE.

*The Medical Standard.*

PENNSYLVANIA is the first of our States to take the step of requiring a fifth, or hospital year, as a prerequisite for the practice of medicine within its borders. Its State Board of Medical Examiners has announced that after 1914 such a fifth year will be made compulsory. This ruling is said to have the support of the two leading medical schools of Philadelphia, the Jefferson Medical College and the Medical Department of the University of Pennsylvania. Such a law would work no considerable hardship upon their graduates, since fully 90 per cent. of these young men are already securing hospital interneships. The law might, however,



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*By J. H. Hurst, M.D., Indian Springs, Tenn.*

I have had many interesting cases of skin diseases come under my observation in which Resinol ointment has given excellent results. I have been prescribing this preparation for over fifteen years and beg to submit case reports of two typical instances of its successful use.

CASE 1.—Mrs. C., aged 58, came under my care suffering with a very aggravated case of eczema. The disease covered both hands and extended to about the elbows. It had continued over a period of something like six months and was one continuous eruption, giving excruciating pain, especially when getting the skin wet. It had been treated at home with various lotions, salves, etc., and by one very able young doctor, a friend of mine. The patient finally asked me to "try my hand at the case." The skin was first thoroughly softened with Resinol soap and dried. After this the Resinol ointment was thoroughly rubbed in every night and morning. *Itching ceased after the first application* and the case went on to rapid recovery, the skin being perfectly smooth in a week.

CASE 2.—Mr. James B. presented a marked case of tinea sycosis (barber's itch). Numerous remedies had been tried with only temporary relief. The disease had become chronic, covering a period of over two years. These cases are very hard to handle with ordinary treatment. I prescribed Resinol ointment, the skin being well softened by Resinol soap and hot water first. The Resinol ointment was used every night, on retiring, no shaving being permitted, but clipping the beard with sharp scissors. This treatment was entirely successful in about two weeks. After three years there has been no return.

NOTE.—While Resinol ointment has its largest application in the treatment of skin diseases, and especially in the speedy control of itching, yet its properties are such that it lends itself to a wide range of other uses. As a dressing for burns and scalds, ulcers, boils and similar lesions, for severe chafing, and for piles, it is convenient, uniform and efficient. Physicians wishing to test Resinol ointment and Resinol soap can obtain samples on application. Also ask for a miniature Resinol shaving stick.

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mean much to physicians coming from other States to practice in Pennsylvania.

Such a law has much to recommend it. The time spent in a hospital after the completion of the theoretical course is time well spent. By giving practical facility in the technique of the physician's work it is simply invaluable. Most hospitals provide for the maintenance of their internes, so the financial burden will not be a hard one. On the whole, we hope that other States will follow the trail blazed by Pennsylvania.

## PROBLEMS OF THE SOUTH.

*Southern Medical Journal.*

THIS office has been favored by Dr. John L. Jelks of Memphis, with a copy of an address with the above title, which he delivered at Jonesboro, Ark., October 8, and at Paragould, Ark., December 4, 1912.

The article is devoted principally to the sanitation of railroads, their cars, their rights of way, buildings, etc., and he demonstrates that it pays such huge corporations to see that their premises, from one end of their line to the other, are sanitary and attractive. He shows that where the depot is a blotch on the landscape and a menace to health, the employes lack the health and spirit required for full efficiency. He speaks of how Miami and Palm Beach, once desolate resorts of alligators and snakes, have been rendered sanitary and beautiful by Flagler, thus profiting him over half a million dollars. He speaks of the fly in a way to add shudders of nausea to the resentment we already feel at his intrusion.

He is an ardent advocate of Government aid in sanitation work, and though a good Southerner, is not afraid the doctrine of "States' rights" will be annihilated thereby. The address is a good, strong, ringing appeal to his fellow-citizens everywhere to wake up and join the crusade against flies, mosquitoes and dirt. The *Journal* does not know his politics—politics in Tennessee are, as the darkey said when they hauled him out of the wrong chicken house, "powerful mixed"—but as far as medicine, energy and sanitation go, Dr. Jelks is certainly a Progressive.

## THE UNPOPULARITY OF MORALITY.

*The Medical Standard.*

WE agree with the *Clinique*, which, in commenting upon the alarming spread of venereal diseases in this country, takes occasion to call attention to the unpopularity of sexual morality as a factor to be reckoned with. There is a growing attitude of tolerance for illicit living among young men. To be sexually unclean has become a joke, and an immoral liaison is too often considered a thing to boast about. Prudency permeates our literature, art, drama, philosophy, even our "moral" disquisitions on "sex hygiene." As a natural result of all this, of course, we may expect a large percentage of our youth to acquire the venereal diseases.

We confess a firm belief in the old-fashioned morality as a means of developing manliness and womanliness, as well as in the preservation of health. Clean living, clean thinking and hard work provide a sufficient panacea for restraining the too hot fires of passion, and medical men should certainly use all their efforts to show that it pays to lead lives that are free from the moral and physical danger of indiscriminate sexual indulgence.

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(Signed) J. ALEX. HILLARY, JR.,
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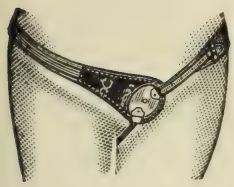

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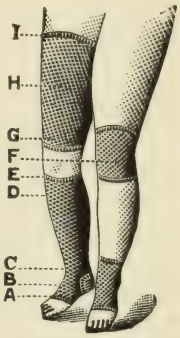


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THIS Directory is maintained mainly for the benefit of local firms seeking the patronage of physicians and their families. Only well established and reliable concerns will be represented, and doubtless the space at our disposal will be constantly in demand. In responding to these exploitations, the reader will find it mutually advantageous to mention the MARYLAND MEDICAL JOURNAL.

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## *Publishers' Department.*

### Danger Due to Substitution.

HARDLY another of all the preparations in existence offers a wider scope to imposition under the plea of "just as good" than the scientifically standardized Eucalyptol.

The most recent fraud practiced in regard to this product is an attempt to profit by the renown of the firm of Sander & Sons. In order to foist upon the unwary a crude oil, that had proved injurious upon application, the firm name of Sander & Sons is illicitly appropriated, the make-up of their goods imitated, and finally the medical reports commenting on the merits of their excellent preparation are made use of to give the desired luster to the intended deceit.

This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

### The New Treatment for Pneumonia.

AFTER long and laborious clinical study—extending, in fact, over a period of more than twenty months—Messrs. Parke, Davis & Co. announce the addition of Pneumonia Phylacogen to their list of therapeutic agents. This product is designed for the treatment of pneumonia or any infection caused by the pneumococcus. Administered in the early stage of the disease, it is said to cut short the pneumonic process in a manner that is truly remarkable.

Pneumonia Phylacogen has been administered to patients of all ages and of many nationalities, with highly gratifying results in a large majority of cases. "From experience gained in the study of typical cases treated under favorable circumstances," one writer remarks, "we are led to believe that almost every case of pneumonia seen within the first twenty-four hours after the initial chill will recover if properly treated with Phylacogen." Another observer, a professor in one of the large American medical schools, pays the product a high compliment in these words: "Pneumonia Phylacogen is the only therapeutic agent in my experience that has ever shown a definite threapeutic action on the pneumonic process."

In view of the fact that pneumonia is one of the commonest and most fatal of infec-

tions (it is said upon good authority that it causes more deaths than tuberculosis, scarlet fever and smallpox combined), the new Phylacogen gives promise of a veritable therapeutic blessing.

---

**Diamond Antiseptics, Lilly.**

Diamond Antiseptics, Lilly, are justly popular among physicians and surgeons, because they are rapidly soluble, accurate in grainage and safest in office use or in leaving with the patient. The presence of citric acid hastens solution, prevents precipitation of insoluble mercury in neutral solutions in hard water or when brought in contact with albuminous liquids.

Diamond Antiseptics, Lilly, have in addition to the advantages noted a characteristic shape, which minimizes the possibility of error in using them. In addition, the nature of the tablets is at once apparent, because each one is marked "poison," and they are packed in diamond shaped bottles, with serrated corners, plainly labeled "poison."

Bichloride of mercury, available as Diamond Antiseptics, Lilly, is the most generally useful germicide at the physician's command.

---

**Safe, Pleasant and Thorough.**

The advantages in using Pil. Cascara Comp. (Robins) are safety and pleasantness if dose is graduated to suit; certainty and thoroughness in results; universal adaptability as an aid to any similar or dissimilar compound. No mercury, strychnia nor belladonna. Two strengths—mild (1 gr.) and strong (4 grs.) aid the physician in dosage.

Uralithic salt is truly an acid eliminant and gentle laxative. In the treatment of lithemia, rheumatism, cystitis, it gives prompt relief. Its composition is of the highest degree of potency, a half teaspoonful being stronger than one teaspoonful of many similar preparations. Can often be taken when the stomach revolts against other compounds. In administering to those with delicate stomachs and children, palatability is secured by giving suitable dose in lemonade or with any appropriate flavoring.

---

**The Pallid School Girl.**

In view of the modern methods of education, which force the scholar at top speed, it is not to be wondered at that the strenuous courses of study prescribed for the adolescent girl more than frequently result in a general breakdown of both health and spirits. Each winter the physician is consulted in such cases, and almost always finds the patient anemic, nervous and more or less devitalized. In most instances a rest of a week or two, together with an efficient tonic, enables the patient to take up her school work again with renewed energy. Pepto-Mangan (Gude) is just the hematinic needed, as it acts promptly to increase the red cells and hemoglobin, and to tone up the organism generally. It is particularly suitable for young girls, because it never induces or increases constipation.

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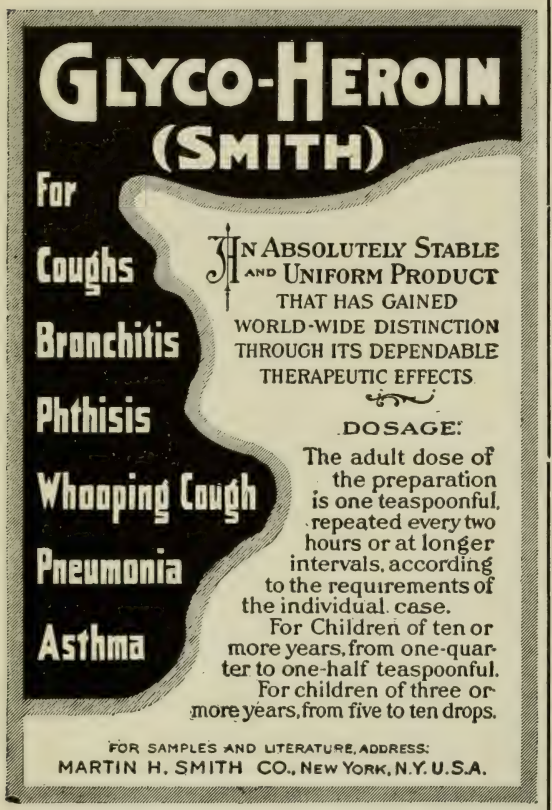
**Tranquillity During General Infections.**

One of the most urgent needs during a severe general infection—typhoid, for instance—that of securing rest for the patient, is satisfactorily secured by means of Pasadyne (Daniel). The advantages of this product for the purpose named will be better appreciated when it is recalled that Pasadyne is the Concentrated tinct. of Passiflora Incarnata compound, the above name being employed to distinguish Daniel's product from others. Pasadyne (Daniel) possesses soporific properties in a marked degree, with the further advantage that it is free from the disagreeable after-effects of other potent hypnotic agents. Pasadyne (Daniel) may be advantageously employed whenever a sedative is indicated.

---

**To Promote Digestive Tone.**

When the functional activity of the digestive tract has been impaired by concomitant diseases, and on this account the nutritive processes are unable to serve the body effectually, Seng is always indicated. This preparation is derived from Panax (Ginseng) and is pleasant to take as well as promptly active in enticing an appetite, gently stimulating the flow of digestive secretions, and giving tone to the or-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gans of digestion generally. Seng acts along the line of "physiological suggestion" rather than as a substitute for the digestive ferments. In other words, it promptly stimulates the secretory activity of the stomach and intestines, so that there is a speedy return to normal physiological functionating. The dose, one to two teaspoonfuls, may be administered before or during a meal. When given alone, it is preferably administered in a small amount of water. The significance of loss of appetite as a forerunner of many serious diseases is well appreciated by the astute diagnostician and clinician. It is in such instances that Seng is valuable in greatest measure as a dependable prophylactic. By stimulating flagging digestive and assimilative functions in the beginning, it often prevents what would surely be serious and intractable nutritional disorders later.

---

**A Therapeutic Point Worthy Attention.**

A FEATURE that has contributed to make Cord. Ext. Ol. Morrhuae Comp. (Hagee) so widely popular is the ease with which it is tolerated during the hottest kind of weather. This is a marked advantage, and one well worthy the physician's consideration, for the need of a tissue food such as Cord. Ext. Ol. Morrhuae Comp. (Hagee) may be just as pressing in an individual case in summer months as during the coldest weather.

By the same token this product is especially well adapted to the needs of those with a delicate gastric apparatus.

---

**Functional Disturbances of the Liver.**

WHEN one stops to think of the work the liver is called upon to do in the human economy and the excessive burden so frequently placed upon it by errors of diet, faulty methods of living, etc., it is really surprising that this great organ—the largest gland of the body—does not become deranged more often than it does.

Clinical study has shown, however, that the liver is much more subject to functional disturbance than is generally realized. The opinion has been growing for some time, therefore, that not a few obscure conditions of the intestines, particularly those grouped under the term "auto-intoxication," should be attributed to sluggishness or torpidity of the liver processes.

In view of this, there is an increasing demand for a cholagogue that can be relied upon to stimulate the functional activity of the liver without at the same time producing a degree of catharsis that is neither necessary nor desired. Many and various are the drugs that have been tested with this in view, but practically the only one that has met the situation is that long known and widely used preparation of Chionanthus Virginica, Chionia.

This product is exceedingly effective as a stimulator of hepatic processes, and administered in proper dosage it is not only an effective cholagogue, but what is especially important, it can be relied upon to produce its effects without causing undue activity of the bowels. The prompt influence of Chionia on hepatic functions consequently gives it a broad range of usefulness, not only in overcoming liver disorders themselves, but also the various affections that are dependent on hepatic deficiency or derangement. It is indicated in acute and chronic hepatitis, catarrhal jaundice of cholangitis, biliousness, chronic intestinal catarrh, intestinal putrefaction, auto-intoxication and all maladies caused or aggravated by derangement of the liver.

The significant feature attending the use of

Chionia is that it always acts by promoting or augmenting natural processes—never by superseding them. It belongs, therefore, to the class of remedies aptly designated as physiologic, for its whole action is to restore and maintain normal or physiologic conditions of the liver.

### A Systemic Boost.

It is safe to say that the average physician is called upon to prescribe a tonic more frequently than any one other form of medication, unless it be a cathartic. Patients who are patients solely because they are tired, "run down" and generally debilitated are constant visitors at the physician's office. Such individuals need something that will boost them up to their normal point of resistance and then hold them there—in other words, not a mere temporary stimulation, with secondary depression, but a permanent help to the revitalization of the blood and a general reconstruction. Pepto-Mangan (Gude) is not only prompt in action as an encourager of appetite and better spirits, but is also distinctly efficient as a blood builder and systemic reconstituent. It is pleasant, non-irritant, free from constipating effect and does not stain the teeth. It is thus a general constitutional tonic of positive service in all conditions of general devitalization.

### Vaso-Motor Derangements.

The part played by the vaso-motor system in countless diseases is at last thoroughly recognized. As a consequence, circulatory disorders are among the most common functional ailments that the modern physician is called upon to correct. Various heart tonics and stimulants are usually employed, but the effect of these is rarely more than temporary. To re-establish a circulatory equilibrium that offers real and substantial relief from the distressing symptoms that call most insistently for treatment requires a systematic building up of the whole body. Experience has shown that no remedy at the command of the profession is more serviceable in this direction than Gray's Glycerine Tonic Comp.

For nearly 20 years this standard tonic has filled an important place in the armamentarium of the country's leading physicians. Its therapeutic efficiency in restoring systemic vitality and thus overcoming functional disorders of the vaso-motor or circulatory system is not the least of the qualities that account for its widespread use. The results, however, that can be accomplished in many cases of cardiac weakness have led many physicians to employ it almost as a routine remedy at the first sign of an embarrassed or flagging circulation.

### Dressings in Suppurating Wounds.

The healing of suppurating wounds may be expedited in a marked degree by the use of Ecthol (Battle). In addition to a germicidal influence it adds to cellular resistance, as a result of which the luxuriant germ growth becomes inhibited, until finally the purulent process becomes reduced to the point where the resistance of the involved tissues turns the tide toward healthy granulation. Where such wounds are of more than ordinary size or severity, the internal administration of Ecthol has proven a most useful adjunct to the local treatment.

### The Safe Bichloride Tablet.

Among all classes of patients, and even among members of the medical profession, each year death claims its toll from accidental or indiscriminate use of bichloride of mercury tablets.

The means to avert error are largely in the hands of those who prescribe or dispense bichloride tablets, and the most reasonable assurance of safety lies in recommending tablets that minimize the danger to the user and are surrounded by the most reasonable safeguards.

"Diamond Antiseptics," the trade name for the bichloride tablets manufactured by Eli Lilly & Co., meet the requirements of the physician for tablets that are highly efficient and safe for him to use in his practice, and at the same time afford his patients the greatest possible protection.

These tablets are hand-molded, rough to the touch and disintegrate rapidly and wholly. They are of diamond shape, and are distinctly marked "Poison." In addition, they are packed in conspicuously-labeled, diamond-shaped bottles with serrated edges, a warning manifested to the most careless, even in the dark. The safeguards thrown around these tablets are an anticipation of legal requirements for public safety, and are worthy the physician's insistence on the Lilly brand "Diamond Antiseptics" in ordering or prescribing bichloride of mercury tablets.

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# Summary of Results of Examination Held by the Board of Medical Examiners of Maryland, June 17, 18, 19 and 20, 1913.

| No. | College of Graduation. | Anatomy | Surgery | Pathology | Obstetrics | Practice | Chemistry | Materia Medica | Therapeutics | Physiology | Total | Average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | University of Maryland, '11 | 75 | .. | 79 | .. | 75 | .. | .. | 91 | .. | ... | .. |
| 2 | Women's Medical of Penna., '10 | 75 | 75 | 79 | .. | 75 | .. | .. | .. | .. | ... | .. |
| 3 | University of Vienna, '06 | 77 | 75 | 77 | 75 | 75 | 99 | 75 | 90 | 80 | 723 | 80 |
| *4 | Maryland Medical, '12 | 63 | 56 | 00 | 76 | 55 | 75 | 75 | 67 | 45 | 506 | 56 |
| 5 | Johns Hopkins, '11 | 78 | 89 | 97 | 91 | 93 | 83 | 75 | 86 | 84 | 776 | 86 |
| 6 | Baltimore Medical, '12 | 75 | .. | 75 | .. | 75 | .. | .. | .. | .. | ... | .. |
| 7 | Johns Hopkins | 90 | .. | .. | .. | .. | 97 | 86 | .. | 88 | ... | .. |
| 8 | Johns Hopkins | 81 | .. | .. | .. | .. | 100 | 66 | .. | 78 | ... | .. |
| 9 | University of Pennsylvania, '11 | 93 | 90 | 100 | 79 | 93 | 85 | 86 | 83 | 84 | 793 | 88 |
| 10 | Johns Hopkins | 79 | .. | .. | .. | .. | 95 | 57 | .. | 77 | ... | .. |
| 11 | University of Maryland, '11 | 77 | 75 | 75 | 70 | 69 | 68 | 63 | 67 | 75 | 639 | 71 |
| 12 | McGill University, '08 | 90 | 85 | 97 | 89 | 86 | 99 | 91 | 96 | 96 | 829 | 92 |
| 13 | Johns Hopkins | 75 | .. | .. | .. | .. | 84 | 42 | .. | 63 | ... | .. |
| 14 | University of Maryland, '12 | 84 | 75 | 71 | 78 | 75 | 96 | 75 | 86 | 75 | 715 | 79 |
| 15 | Maryland Medical, '12 | 59 | 71 | .. | .. | .. | 68 | .. | .. | .. | ... | .. |
| 16 | Johns Hopkins, '06 | 75 | 76 | 89 | 90 | 79 | 85 | 58 | 93 | 75 | 720 | 80 |
| 17 | University of Maryland, '13 | 72 | 74 | 83 | 92 | 70 | 75 | 75 | 85 | 76 | 702 | 78 |
| 18 | University of Maryland, '11 | 55 | 60 | 61 | 77 | 75 | 53 | 54 | 57 | 52 | 544 | 60 |
| 19 | University of Maryland, '13 | 84 | 76 | 93 | 90 | 82 | 87 | 76 | 87 | 75 | 750 | 83 |
| 20 | Johns Hopkins | 93 | .. | .. | .. | .. | 100 | 67 | .. | 75 | ... | .. |
| 21 | Johns Hopkins | 68 | .. | .. | .. | .. | 96 | 34 | .. | 54 | ... | .. |
| 22 | Johns Hopkins, '13 | 85 | 75 | 100 | 95 | 86 | 85 | 95 | 91 | 100 | 812 | 90 |
| 23 | Johns Hopkins, '13 | 85 | 83 | 95 | 92 | 80 | 96 | 75 | 92 | 83 | 781 | 87 |
| 24 | Johns Hopkins, '13 | 92 | 79 | 94 | 92 | 91 | 95 | 90 | 91 | 87 | 811 | 90 |
| 25 | Johns Hopkins, '13 | 84 | 80 | 99 | 90 | 85 | 92 | 65 | 94 | 76 | 765 | 85 |
| 26 | Johns Hopkins, '13 | 79 | 77 | 99 | 92 | 82 | 90 | 75 | 84 | 75 | 753 | 84 |
| 27 | University of Maryland, '12 | 73 | 67 | 95 | 80 | 63 | 72 | 69 | 78 | 68 | 665 | 74 |
| 28 | University of Maryland, '13 | 70 | 77 | 94 | 96 | 75 | 96 | 63 | 100 | 63 | 734 | 81 |
| 29 | University of Maryland, '13 | 83 | 76 | 90 | 89 | 75 | 84 | 77 | 92 | 75 | 741 | 82 |
| 30 | College of Physicians and Surg., Balto., '13 | 96 | 80 | 84 | 75 | 87 | 98 | 94 | 90 | 92 | 796 | 88 |
| 31 | University of Maryland, '13 | 91 | 82 | 94 | 89 | 88 | 81 | 79 | 94 | 93 | 791 | 88 |
| 32 | Maryland Medical, '12 | 75 | 44 | .. | 52 | 66 | 75 | 76 | 69 | .. | ... | .. |
| 33 | Maryland Medical, '12 | 65 | .. | .. | .. | 69 | 75 | 65 | .. | 65 | ... | .. |
| 34 | Maryland Medical, '12 | 77 | .. | .. | .. | .. | .. | .. | .. | .. | ... | .. |
| 35 | Maryland Medical, '12 | .. | .. | .. | .. | .. | 61 | 54 | 75 | 63 | ... | .. |
| 36 | University of Maryland, '13 | 78 | 70 | 78 | 87 | 75 | 75 | 75 | 75 | 69 | 682 | 76 |
| 37 | Jefferson Medical, '02 | 65 | 67 | 64 | .. | .. | 43 | 75 | .. | 62 | ... | .. |
| 38 | Maryland Medical, '12 | 66 | 44 | 50 | 75 | .. | 78 | 75 | 84 | 63 | 535 | .. |
| 39 | Johns Hopkins, '13 | 75 | 81 | 87 | 92 | 84 | 88 | 59 | 87 | 75 | 728 | 81 |
| 40 | Georgetown University | 94 | .. | .. | .. | .. | 84 | 75 | .. | 83 | ... | .. |
| 41 | University of Maryland, '13 | 96 | 77 | 95 | 88 | 75 | 87 | 77 | 94 | 96 | 785 | 87 |
| 42 | Johns Hopkins, '13 | 63 | 80 | 93 | 92 | 79 | 98 | 64 | 62 | 81 | 712 | 79 |
| 43 | Johns Hopkins | 82 | .. | .. | .. | .. | 85 | 75 | .. | 75 | ... | .. |
| 44 | University of Maryland, '13 | 90 | 80 | 93 | 94 | 81 | 90 | 65 | 88 | 88 | 769 | 85 |
| *45 | Baltimore Medical, '13 | 77 | 68 | 00 | 83 | 59 | 80 | 75 | 79 | 60 | 581 | 64 |
| 46 | Johns Hopkins, '13 | 92 | 80 | 95 | 88 | 86 | 94 | 76 | 88 | 77 | 776 | 86 |
| 47 | Johns Hopkins, '13 | 89 | 79 | 90 | 92 | 80 | 96 | 59 | 88 | 78 | 751 | 83 |
| 48 | University of Maryland, '13 | 81 | 73 | 84 | 80 | 76 | 75 | 75 | 67 | 75 | 686 | 76 |
| 49 | Jefferson Medical, '13 | 98 | 91 | 59 | 93 | 90 | 89 | 78 | 84 | 84 | 766 | 85 |
| 50 | University of Maryland, '12 | 81 | .. | 79 | .. | .. | 80 | .. | .. | 78 | ... | .. |
| 51 | Johns Hopkins, '13 | 85 | 79 | 94 | 86 | 81 | 90 | 83 | 86 | 77 | 761 | 85 |
| 52 | University of Pennsylvania, '13 | 91 | 92 | 94 | 94 | 87 | 88 | 86 | 88 | 88 | 808 | 90 |
| 53 | Johns Hopkins, '13 | 79 | 80 | 94 | 94 | 80 | 80 | 86 | 87 | 77 | 757 | 84 |
| 54 | Maryland Medical, '09 | .. | .. | .. | .. | .. | 67 | .. | .. | .. | ... | .. |
| 55 | Johns Hopkins, '13 | 83 | 75 | 99 | 89 | 80 | 95 | 76 | 79 | 64 | 740 | 82 |
| 56 | University of Maryland, '13 | 78 | 66 | 49 | 75 | 64 | 78 | 63 | 76 | 73 | 622 | 69 |
| 57 | Johns Hopkins, '13 | 94 | 76 | 99 | 92 | 82 | 95 | 86 | 82 | 84 | 790 | 88 |
| 58 | Maryland Medical, '12 | 75 | .. | .. | .. | .. | .. | 75 | 75 | 75 | ... | .. |
| 59 | University of Maryland, '13 | 47 | 73 | 85 | 84 | 65 | 69 | 77 | 84 | 75 | 659 | 73 |
| 60 | Johns Hopkins | 69 | .. | .. | .. | .. | 95 | 53 | .. | 75 | ... | .. |
| 61 | Maryland Medical, '11 | 75 | 56 | 57 | 79 | 67 | 63 | 66 | 90 | 62 | 615 | 68 |
| 62 | Jefferson Medical, '12 | 87 | 81 | 79 | 91 | 83 | 94 | 92 | 92 | 80 | 779 | 86 |
| 63 | Johns Hopkins, '13 | 96 | 79 | 84 | 93 | 83 | 82 | 64 | 81 | 77 | 739 | 82 |
| 64 | George Washington University, '13 | 95 | 78 | 82 | 87 | 80 | 82 | 75 | 80 | 80 | 739 | 82 |
| 65 | Jefferson Medical, '13 | 85 | 75 | 84 | 94 | 64 | 83 | 75 | 83 | 75 | 718 | 80 |
| 66 | University of Berlin, '05 | 92 | 79 | 79 | 92 | 64 | 97 | 64 | 66 | 66 | 699 | 78 |
| 67 | George Washington University, '12 | 80 | 75 | 84 | 91 | 79 | 95 | 89 | 82 | 82 | 757 | 84 |
| 68 | University of Maryland | 79 | .. | .. | .. | .. | 89 | 79 | .. | 81 | ... | .. |
| 69 | Maryland Medical, '11 | 77 | 75 | .. | .. | 76 | .. | .. | 85 | 75 | ... | .. |
| 70 | Baltimore Medical, '13 | 85 | 74 | 84 | 81 | 91 | 94 | 88 | 89 | 82 | 768 | 85 |
| 71 | Baltimore Medical, '13 | Failed to appear. | | | | | | | | | | |
| 72 | George Washington University, '11 | 82 | 78 | 96 | 89 | 82 | 88 | 48 | 77 | 64 | 704 | 78 |
| 73 | Johns Hopkins, '13 | Failed to appear. | | | | | | | | | | |

*In numbers 4 and 45 the correction (00) means that examination was made in these branches, but no per cent. was obtained.

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## Summary of Results of Examination Held by the Board of Medical Examiners of Maryland, June 17, 18, 19 and 20, 1913.—(*Continued.*)

| No. | College of Graduation. | Anatomy | Surgery | Pathology | Obstetrics | Practice | Chemistry | Materia Medica | Therapeutics | Physiology | Total | Average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 74 | Jefferson Medical, '13 | 88 | 82 | 92 | 84 | 87 | 82 | 87 | 82 | 80 | 764 | 85 |
| 75 | Woman's Medical, '13 | 75 | 96 | 100 | 89 | 81 | 89 | 75 | 94 | 58 | 757 | 84 |
| 76 | Baltimore Medical, '13 | 75 | 72 | 83 | 93 | 79 | 99 | 75 | 80 | 82 | 738 | 82 |
| 77 | Johns Hopkins, '12 | 88 | 83 | 92 | 80 | 86 | 83 | 86 | 90 | 86 | 774 | 86 |
| 78 | Johns Hopkins, '13 | 93 | 78 | 97 | 83 | 79 | 95 | 75 | 79 | 81 | 760 | 84 |
| 79 | Johns Hopkins, '13 | 80 | 80 | 100 | 94 | 80 | 96 | 83 | 97 | 85 | 795 | 88 |
| 80 | Johns Hopkins, '13 | 74 | 95 | 98 | 79 | 85 | 95 | 58 | 69 | 75 | 728 | 81 |
| 81 | Johns Hopkins, '13 | 93 | 79 | 94 | 90 | 85 | 97 | 79 | 72 | 82 | 771 | 86 |
| 82 | Johns Hopkins, '13 | 86 | 80 | 99 | 93 | 84 | 98 | 82 | 79 | 77 | 778 | 86 |
| 83 | University of Maryland, '13 | 64 | 78 | 79 | 97 | 75 | 60 | 75 | 71 | 76 | 675 | 75 |
| 84 | Johns Hopkins | 90 | .. | .. | .. | .. | 96 | 87 | .. | 75 | ... | .. |
| 85 | Johns Hopkins | 95 | .. | .. | .. | .. | 97 | 43 | .. | 80 | ... | .. |
| 86 | Johns Hopkins | 93 | .. | .. | .. | .. | 100 | 75 | .. | 77 | ... | .. |
| 87 | Johns Hopkins | 89 | .. | .. | .. | .. | 96 | 75 | .. | 75 | ... | .. |
| 88 | University of Maryland | 76 | .. | .. | .. | .. | 82 | 85 | .. | 75 | ... | .. |
| 89 | University of Maryland | 75 | .. | .. | .. | .. | 97 | 94 | .. | 84 | ... | .. |
| 90 | University of Maryland | 92 | .. | .. | .. | .. | 99 | 93 | .. | 83 | ... | .. |
| 91 | Johns Hopkins, '13 | 94 | 76 | 97 | 79 | 89 | 95 | 80 | 90 | 94 | 794 | 88 |
| 92 | University of Maryland | 85 | .. | .. | .. | .. | 97 | 80 | .. | 78 | ... | .. |
| 93 | University of Maryland | 90 | .. | .. | .. | .. | 97 | 89 | .. | 83 | ... | .. |
| 94 | University of Maryland | 80 | .. | .. | .. | .. | 86 | 84 | .. | 80 | ... | .. |
| 95 | College of Physicians and Surg., Balto., '13 | 75 | 82 | 94 | 91 | 84 | 80 | 75 | 93 | 75 | 749 | 83 |
| 96 | University of Maryland, '13 | 71 | 76 | 82 | 91 | 62 | 89 | 60 | 76 | 59 | 666 | 74 |
| 97 | University of Maryland | 76 | .. | .. | .. | .. | 94 | 77 | .. | 75 | ... | .. |
| 98 | University of Maryland | 73 | .. | .. | .. | .. | 77 | 75 | .. | 67 | ... | .. |
| 99 | University of Maryland | 79 | .. | .. | .. | .. | 75 | 81 | .. | 80 | ... | .. |
| 100 | University of Maryland | 91 | .. | .. | .. | .. | 100 | 76 | .. | 83 | ... | .. |
| 101 | Johns Hopkins, '13 | 85 | 86 | 99 | 95 | 88 | 87 | 87 | 90 | 75 | 792 | 88 |
| 102 | University of Maryland | 94 | .. | .. | .. | .. | 91 | 79 | .. | 75 | ... | .. |
| 103 | University of Maryland, '13 | 84 | 82 | 81 | 93 | 75 | 75 | 88 | 96 | 82 | 756 | 84 |
| 104 | Johns Hopkins, '13 | 88 | 80 | 93 | 91 | 80 | 89 | 83 | 91 | 80 | 775 | 86 |
| 105 | University of Maryland, '12 | 97 | 77 | 82 | 75 | 66 | 95 | 75 | 61 | 84 | 712 | 79 |
| 106 | University of Maryland | 80 | .. | .. | .. | .. | 89 | 62 | .. | 64 | ... | .. |
| 107 | University of Maryland, '13 | 73 | 80 | 88 | 94 | 75 | 60 | 80 | 71 | 63 | 684 | 76 |
| 108 | Johns Hopkins | 92 | .. | .. | .. | .. | 98 | 83 | .. | 86 | ... | .. |
| 109 | Johns Hopkins | 85 | .. | .. | .. | .. | 90 | 53 | .. | 80 | ... | .. |
| 110 | Johns Hopkins, '13 | 59 | 63 | 79 | 92 | 75 | 52 | 75 | 54 | 75 | 624 | 69 |
| 111 | University of Maryland | 80 | .. | .. | .. | .. | 90 | 90 | .. | 84 | ... | .. |
| 112 | Medico-Chirurgical, Phila., '12 | 79 | 85 | 85 | .. | 75 | .. | 76 | .. | 75 | ... | .. |
| 113 | University of Maryland | 83 | .. | .. | .. | .. | 95 | 89 | .. | 75 | ... | .. |
| 114 | University of Maryland, '13 | 93 | 91 | 89 | 80 | 75 | 88 | 75 | 87 | 89 | 767 | 85 |
| 115 | Woman's Medical of Penna., '13 | 80 | 89 | 81 | 91 | 90 | 96 | 82 | 82 | 78 | 769 | 85 |
| 116 | Medical College of Virginia, '13 | 67 | 76 | 79 | 77 | 68 | 75 | 80 | 64 | 65 | 651 | 72 |
| 117 | Meharry Medical, '13 | 57 | 59 | 57 | 66 | 57 | 70 | 59 | 58 | 50 | 533 | 59 |
| 118 | Medico-Chirurgical, Phila., '13 | 94 | 76 | 82 | 91 | 83 | 78 | 81 | 75 | 80 | 740 | 82 |
| 119 | Johns Hopkins, '13 | 82 | 79 | 88 | 90 | 84 | 97 | 89 | 76 | 86 | 771 | 86 |
| 120 | Maryland Medical, '12 | 40 | 71 | 52 | 70 | 60 | 50 | 64 | 82 | 42 | 531 | 59 |
| 121 | University of Maryland | 96 | .. | .. | .. | .. | 95 | 89 | .. | 90 | ... | .. |
| 122 | Johns Hopkins, '13 | 93 | 87 | 99 | 78 | 88 | 100 | 75 | 88 | 75 | 783 | 87 |
| 123 | University of Maryland | 90 | .. | .. | .. | .. | 77 | 78 | .. | 81 | ... | .. |
| 124 | College of Physicians and Surg., Balto., '13 | 75 | 74 | 81 | 70 | 64 | 93 | 76 | 77 | 66 | 675 | 75 |
| 125 | University of Maryland | 94 | .. | .. | .. | .. | 99 | 93 | .. | 75 | ... | .. |
| 126 | Ohio Eclectic, '12 | 71 | 53 | 67 | 83 | 70 | 69 | 38 | 75 | 50 | 576 | 64 |
| 127 | Meharry Medical, '13 | 67 | 66 | 67 | 69 | 79 | 75 | 60 | 69 | 55 | 607 | 67 |
| 128 | Woman's Medical, Phila., '12 | 88 | 77 | 95 | 92 | 75 | 98 | 75 | 86 | 82 | 768 | 85 |
| 129 | University of Maryland | 74 | .. | .. | .. | .. | 84 | 79 | .. | 80 | ... | .. |
| 130 | College of Physicians and Surg., Balto., '13 | 74 | 78 | 81 | 94 | 75 | 84 | 67 | 83 | 83 | 719 | 80 |
| 131 | College of Physicians and Surg., Balto., '13 | 80 | 76 | 79 | 80 | 67 | 60 | 58 | 84 | 66 | 650 | 72 |
| 132 | University of Maryland, '13 | 90 | 79 | 82 | 89 | 80 | 88 | 67 | 81 | 94 | 750 | 83 |
| 133 | Medical College of Virginia, '13 | 76 | 75 | 69 | 88 | 70 | 75 | 64 | 87 | 71 | 675 | 75 |
| 134 | Temple University, '13 | 56 | 76 | 72 | 90 | 85 | 60 | 64 | 65 | 75 | 643 | 71 |
| 135 | College Physicians and Surg., Boston, '11 | 41 | 70 | 54 | 75 | 57 | 60 | 78 | 77 | 66 | 578 | 64 |
| 136 | University of Maryland, '13 | 87 | 76 | 88 | 93 | 82 | 84 | 83 | 85 | 80 | 758 | 84 |
| 137 | Maryland Medical, '12 | 75 | 75 | .. | .. | .. | .. | 75 | .. | 75 | ... | .. |

In the above summary an average of 75 is required of those participating in the examination for the first time in order to secure a license. Those who have failed are eligible to re-examination at the expiration of six months. They are then obliged to receive a rating of 75 in each branch in which they are re-examined before license can be issued. Under the Maryland laws, students who, at the end of their second year, have successfully passed their college examination in Anatomy, Chemistry, Materia Medica and Physiology, are entitled to examination by the Board of Medical Examiners in these branches. The ratings made by these students in the examination known as the "second-year examination" are carried forward and made part of the final examination, when an average of 75 must be obtained to secure a license. We trust that this statement will make clear the apparently incomplete examination of certain participants.

# Diarrhea of Infants

Mellin's Food, 4 level tablespoonfuls
Water (boiled, then cooled) 16 ounces

Analysis of above mixture:

| | |
|---|---|
| Proteins (cereal) - - | .56 |
| Carbohydrates (no starch) | 4.33 |
| Salts - - - - | .23 |
| Water - - - - | 94.88 |
| | 100.00 |

Calories per fluidounce = 6.2

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Milk, preferably skimmed, may then be substituted for water — one ounce each day—until regular proportions of milk and water, adapted to the age of the baby are reached.

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# Medical Items.

THE faculty of the Johns Hopkins University gave a reception July 4 in McCoy Hall to the students of the summer school.

THE twenty-third annual session of the New York and New England Association of Railway Surgeons will be held at the Hotel Astor, New York city, on Wednesday, October 22, 1913. A very interesting and attractive program has been arranged. Dr. Hugh H. Young of Baltimore will deliver the "Address in Surgery." Railway surgeons, attorneys and officials and all members of the medical profession are cordially invited to attend.

THE following is a list of those who successfully passed the Maryland State Board Medical Examination, held in Baltimore, June 17-20, 1913, and to whom licenses were granted to register as physicians and surgeons:

Arthur W. Allen, Frank R. Bailey, Philip J. Bean, Charles F. W. Bove, Earle G. Breeding, Harold M. Brown, Humphrey W. Butler, Francis F. Callahan, Noland M. Canter, Henry W. Cave, Leon M. Cavanaugh, Howard L. Cecil, Helen D. Clarke, John W. V. Clifft, George W. Corner, Edwin D. Davis, Frederick L. Detrick, George W. Disbrow, Richard C. Dodson, John B. Donovan, Frank J. Edgett, Charles R. Edwards, Cortlandt W. Elkin, Ernest C. Fishbaugh, Linton Gerdine, Carol Goldenthal, Amos W. Gottschall, Claude D. Hamilton, Leonard Hays, Nathan J. Helfgott, Edward G. Henry, Josiah B. Henneberger, Isaac P. Heymann, Walter R. Holmes, Jr., Lee Howard, Edgar E. Hume, Jr., Isaac B. Hunt, Grace Huse, James L. Jenson, Charles C. W. Judd, Richard F. Kieffer, Howard E. Lecates, Dorothea Lee, Bertrand A. Lillich, Marie Millikin, Arthur H. Morse, Franklin D. Murphy, Elmer Newcomer, Merle C. Newkirk, Walter A. Ostendorf, Grover F. Powers, Raymond J. Quinn, Ernest H. Rahn, William D. Reddish, R. Wayne Richards, Maurice L. Richardson, Iva E. Rowland, Albanus S. Ryland, Raymond H. Ryder, Charles E. Sandoz, Augusta R. Scott, Henry N. Shaw, William F. Shorts, Alex. A. Sienkiewicz, Frederick J. Smith, Gardiner Spring, Jr., James E. Stowers, Charles B. Thompson, Martillus H. Todd, William H. Toulson, Edgar E. Travers, Anna J. Waite, Benjamin F. Weems, Edwin V. Whitaker, Karl M. Wilson and Timothy G. Williams.

### MARRIAGES.

ARTHUR BOND CECIL, M.D., Johns Hopkins Medical School, class of 1909, of Millersville, Md., to Miss Mary Wrightson Caulk of Easton, Md., at Baltimore, July 24, 1913. Dr. and Mrs. Cecil will reside in Los Angeles, Cal., where Dr. Cecil will be connected with the Los Angeles University.

### DEATHS.

THEODORE SAULSBURY, M.D., Physicians and Surgeons, '73, of Burrsville, Md., died at the Delaware State Hospital, Farnhurst, July 24, 1913, aged 65 years. Dr. Saulsbury represented Caroline county in the Legislature in the session of 1908.

JAMES P. CARTER, M.D., University of Maryland, '52, of Gerrardstown, W. Va., died at his home August 2, 1913, aged 87 years.

JOHN FRANCIS GRAHAM, M.D., Baltimore Medical College, '96, died at his home in Marion, Ind., recently, aged 62 years.

JOSEPH C. WUNDER, M.D., University of Maryland, '89, of Baltimore, Md., died of tuberculosis at the State Sanatorium at Sabillasville, July 20, 1913, aged 47 years. Dr. Wunder was the first to introduce diphtheria antitoxin in Baltimore.

PRIDE JONES THOMAS, M.D., University of Maryland, '02, of Wilmington, N. C., died at his home of valvular heart disease, June 24, 1913, aged 38 years.

ISIDORE CLARENCE SMULYAN, M.D., Baltimore Medical College, '01, of Salt Lake City, Utah, died in the Holy Cross Hospital, Salt Lake City, from nephritis, June 30, 1913, aged 35 years.

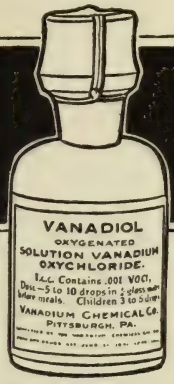
JOSEPH MORTON BUNTING, M.D., Baltimore Medical College, '09, of Kingston, N. Y., died recently at his home, aged 28 years.

JAMES HENRY MURRAY, M.D., Maryland Medical College, '12, of West River, Md., died at St. Luke's Hospital, Jacksonville, Fla., from intestinal obstruction, July 24, 1913, aged 24 years.

MONTE GRIFFITH, M.D., University of Maryland, '96, of Washington, D. C., died at his home in Cherrydale, Va., of angina pectoris, July 11, 1913, aged 51 years.

JOHN G. HUCK, M.D., Physicians and Surgeons, '82, of Baltimore, Md., died at the Johns Hopkins Hospital from heart trouble, August 13, 1913, aged 63 years.

A. S. HOTALING, M.D., Physicians and Surgeons, '94, of Syracuse, N. Y., died at his home from appendicitis, August 8, 1913, aged 40 years.

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***IS THE STOMACH WEAK,***

is its muscular power impaired, and its secretory activity notably diminished

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and one to two teaspoonfuls before meals will not only stimulate local glandular secretion but will substantially aid in re-establishing the physiologic activity of the whole alimentary canal.

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is it losing its power and becoming irregular and weak

?

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and overloaded and the whole system depressed and deranged by the retention of toxic waste material

?

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# Book Reviews.

Diet Lists of the Presbyterian Hospital, New York City. Compiled, with notes, by Herbert S. Carter, A.M., M.D., Consulting Physician to the Lincoln Hospital; Associate in Medicine at Columbia University and Assistant Visiting Physician to the Presbyterian Hospital, New York City. 12mo of 129 pages. Philadelphia and London; W. B. Saunders Company. Baltimore: The Medical Standard Book Co. Cloth, $1 net. 1913.

This little book will be found a good companion when in doubt as regards what diet to give in this or that condition, as well as how to vary the food so as to make it more acceptable to the patient. It contains schedules of regular house, convalescent, soft, milk and liquid diet, typhoid diets, salt-poor diets, purin-free, gastric, diabetic, anticonstipation, low calcium, diarrhea and obesity diets, gastric test meals, Schmidt's intestinal test meal, table of carbohydrate equivalents, special diabetic recipes, miscellaneous recipes, average chemical composition of American foods, Karell treatment for anasarca, etc., and comments upon each and every diet discussed.

---

Sterility in the Male and Female and Its Treatment. By Max Huehner, M.D., New York, Chief, Genito-Urinary Department, Harlem Hospital Dispensary, New York City; Formerly Attending Genito-Urinary Surgeon, Bellevue Hospital, Out-patient Department, and Assistant Gynecologist, Mt. Sinai Hospital Dispensary, New York City; Member American Urological Association; Fellow of the New York Academy of Medicine, etc. New York: Rebman Company, Herald Square Building. Cloth, $2 net. 1913.

The above volume embodies the results of many years' work and investigation upon the subject of sterility by the author. The material was obtained from the genito-urinary clinics of the Harlem and Bellevue hospital dispensaries, and from the gynecologic clinic of Mt. Sinai Hospital Dispensary. The investigations extended over a period of six years, and every case of sterility coming into one of the afternoon classes was referred to the author, and ordered to his office at various periods after coitus, thus making it possible to examine various portions of the genital tract, and thereby accurately determine how far the spermatozoa penetrate in normal and pathological cases, the effect on the spermatozoa of various kinds of douches, catarrhal secretions, inflammations, etc. Condom specimens were examined, and experiments made to determine the effect on living spermatozoa of gonococci, prostatic fluid, chemicals, etc. The writer also goes into the clinical histories of the cases in order to determine what effect heredity, stature, age, etc., have upon the production of sterility. As far as we are aware, the work of Huehner is the first scientific and systematic attempt to determine the behavior of spermatozoa after injection into the female genitalia. The writer states, and justly so, that one writer after another has copied into his textbook the so-called findings of his predecessors without challenge or investigation, thereby disseminating a host of erroneous ideas concerning this very important subject. He even goes so far as to state that you cannot draw definite conclusions from the finding of live

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spermatozoa in condom specimens, as regards the sterility or non-sterility factor being the woman. He also says that most operations done on the female for sterility are performed in the dark, no account being taken as to the cause. After a thorough discussion as to the causes of sterility in the sexes, the author outlines his methods of treatment, together with a statement as to why he selects the particular procedure. It is a book well worth while, and if after a thorough investigation the conclusions are proven wrong, will still justify itself in that it calls attention to a subject which authors have been treating in a stereotyped way instead of investigating scientifically for themselves. Much good should evolve from it.

---

The Career of Dr. Weaver. A Novel. By Mrs. Henry W. Backus. Cloth, decorative; illustrated; 12mo, pp. 373; net, $1.25; postpaid, $1.40. Boston: L. C. Page & Co.

The career of Dr. Weaver is not his alone, nor is it alone the career of the physician who is bidding for wealth and distinction and is oblivious to everything that does not help in his upward climb; it is the type of career which the money-making American of today has carried to such sad excess. Dr. Weaver is a success. He has studied through hardships, seeing always ahead his goal of wealth; after graduation he has started in a modest way, but through studying ways to please women of society has built up a very lucrative practice. Then he founds a hospital, and his idea is that he must "make good" to meet its expenses. His brother, a country practitioner, is called as his assistant, and comes to be his drudge. The younger brother is unknown and is strictly out of the set in which his more prominent brother moves. The younger brother attends the clinics, takes care of the poor and needy, and the older brother goes there only when he can "practice" an operation on some unknown personage before attempting a similar operation on some person whose case will bring him more popularity and wealth. The younger brother, because he is not always able to accept his brother's creed of success, and because he believes in the nobility of his calling, and because he has the deep sympathy of the true physician, is about to break away from the institution owned by his brother, tiring of the hypocrisy of it all, and seeing no change in the future, when the older brother is called to the bedside of the dying Governor. The Governor is delirious and goes back to his younger days when he builded his future on the hearts and souls of those around him, and raves because of his lost happiness. The physician sits there and listens, while the Governor's wife, married to aid in his upward way by her wealth, also hears and thinks "Nellie" was a sister of whom she has never heard, but the physician hears and reads in the ravings a warning.

The story drops here for a few months, and we go back to find Dr. Weaver married to the woman who helped him rise from obscurity to wealth, Dr. Jim working for the cause of progress, and the hospital flourishing. Mrs. Backus has not failed to condemn—through the words of Dr. Jim—the modern evils of fee-splitting, the proprietary hospital, the commercial medical essay, the physician who is not also a good citizen, and the physician who fails to maintain the proper relation between the profession and society. It is a good story, well written, and well worth reading.

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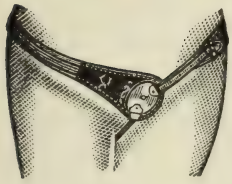

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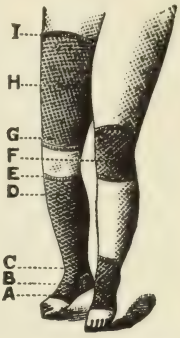


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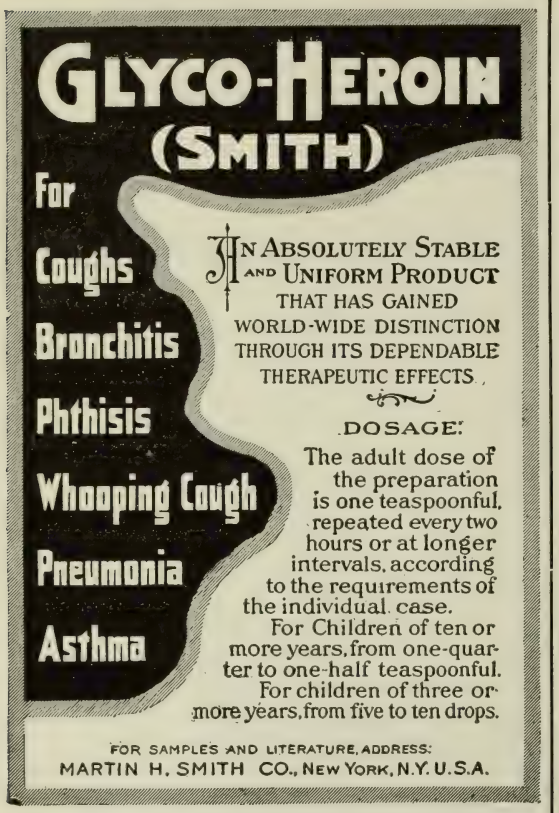
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where the radium ore values are extracted. This residue is then taken to the company's laboratories in Pittsburgh, where by a series of processes, mostly original with the company's staff of experts, radium is produced in the various forms desirable for medical and scientific purposes.

The company has recently made several shipments of radium to Europe for therapeutical applications in hospitals and private clinics. Several of these shipments went to Vienna, Austria, which place is considered the home of radium.

The Standard Chemical Company is constantly adding to its facilities at the mines and mill, and by practical research methods it is progressing in widening the scope and possibilities of radium and its applications. It has already furnished considerable quantities of radium element to representatives of the medical profession in this country, and it is not difficult to foresee that it will be but a very short time when radium treatment for the cure of cancer, rheumatism, gout and other diseases will become popular here, as these treatments are now in European countries, notably in England, France, Germany and Austria, where a large number of cures have already been effected.

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# Medical Items.

The engagement is announced of Dr. Merle D. McCutcheon, Physicians and Surgeons, class of 1908, of East Liverpool, Ohio, to Miss Louise Alberta Sturtevant. The wedding will take place October 1, 1913, at Westminster Presbyterian Church.

The engagement is announced of Dr. E. DeWitt Simpson, Johns Hopkins Medical School, class of 1912, of Rochester, Minn., to Miss Myrtle Harrell Pearce of Minneapolis, Minn. The wedding will take place shortly. Dr. Simpson is a member of the Mayo clinic of St. Mary's Hospital, Rochester, N. Y.

Dr. Clement A. Penrose, Johns Hopkins Medical School, '97, and family, who have been occupying their cottage at Siasconset, Mass., during the summer months, have returned to their town residence, 21 W. Mount Royal avenue.

The public health exhibit of the Maryland Medical and Chirurgical Faculty opened August 11, at the Y. M. C. A. Building, Frederick, Md., and continued a week. Addresses were made on tuberculosis, alcohol, mental and social diseases, and infant mortality.

Drs. H. O. Reik, Walter A. Baetjer, John Ruhrah, W. I. Moss and W. S. Thayer, all of Baltimore, sailed July 11 on the steamship Kaiser Wilhelm II for Bremen, via Plymouth and Cherbourg. They will return to Baltimore in the fall.

## MARRIAGES.

Dr. Charles J. Carey, College of Physicians and Surgeons, '97, of Sykesville, Md., superintendent of the Eastern Shore Hospital, at Cambridge, Md., to Miss Grace Eloise Ridgely, of Carroll county, Md., September 1, 1913, at Sykesville, Md. Immediately after the ceremony Dr. and Mrs. Carey left for Atlantic City. Upon their return they will live in Cambridge.

Leo J. Goldbach, M.D., University of Maryland, '05, to Miss Gertrude Elizabeth Brehm, both of Baltimore, Md., at Baltimore, October 9, 1913.

## DEATHS.

Henry M. Emerick, M.D., College of Physicians and Surgeons, '80, of Milton, Pa., died at his home from acute indigestion August 31, 1913, aged 59 years.

Samuel Rozier Catts, M.D., Baltimore Medical College, '06, of Madison, Ind., died at the home of his father in Alexandria, Va., from tuberculosis, August 29, 1913, aged 36 years.

Daniel Aloysius Shay, M.D., Baltimore University, '01, New York University, N. Y., '04, of Brooklyn, N. Y., died in Marlborough, N. Y., from acute nephritis August 21, 1913, aged 37 years.

John W. McPherson, M.D., Baltimore Medical College, '98, of Haw River, N. C., died suddenly at the home of his father, in Liberty, N. C., July 27, 1913, aged 40 years.

Eugene Fauntleroy Cordell, M.D., University of Maryland, '68, M.A. University of Maryland, 1907, Professor of History of Medicine and Librarian, and a former editor of the Maryland Medical Journal, died at his home, 257 West Hoffman street, Baltimore, Md., August 27, 1913, aged 70 years.

William Wyatt Wiley, University of Maryland, '71, of Cumberland, Md., died after a lingering illness at his home in Cumberland, August 27, 1913, aged 64 years.

William A. Jordan, M.D., College of Physicians and Surgeons, '73, died at his home, 601 East Douglas street, Wichita, Kan., from heart disease, August 19, 1913, aged 67 years. Dr. Jordan was one of the founders of St. Francis' Hospital, Wichita, Kan., and later a member of the staff of the Wichita Hospital.

Isaac Newton Boyd, M.D., College of Physicians and Surgeons, '80, of Etters, Pa., died at his home from heart disease August 21, 1913, aged 60 years. Dr. Boyd taught for seven years in the York Haven School, and was for 20 years a practitioner of Goldsboro, Pennsylvania.

David F. Pennington, M.D., Maryland Medical College, '85, of Washington, D. C., died at his home August 16, 1913, from acute gastritis, aged 62 years. Dr. Pennington was for 20 years president of the Masonic Relief Association of Baltimore, Md., and a resident of that city until 1902.

William Henry McCarthy, M.D., College of Physicians and Surgeons, '91, of Boston, Mass., died at his home August 22, 1913, from appendicitis, aged 70 years. Dr. McCarthy was a member of the Massachusetts Medical Society.

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# Book Reviews.

THE CARE OF THE INSANE AND HOSPITAL MANAGEMENT. By Charles Whitney Page, M.D., Assistant Physician Hartford Retreat, Connecticut, 1871 to 1872 and 1873 to 1888; Superintendent Connecticut Hospital for the Insane, Middletown, 1898 to 1901; Superintendent Danvers State Hospital, Danvers, Mass., 1888 to 1898 and 1903 to 1910; Member of the American Medico-Psychological Association, the Boston Society of Psychiatry and Neurology, the New England Psychiatric Society, the Massachusetts Medical Society. 1912. Boston: W. M. Leonard.

The present volume is a scientific exposition of the treatment of the insane along humanitarian lines. Stress is laid upon non-mechanical restraint of the insane and conditions essential to its success. Along these lines it also enters very thoroughly into the proper selection of a superintendent, his qualifications and duties, the selection of the assistant physicians and their qualifications, the importance of a well-equipped laboratory, and the part it plays, the management of patients, the attendants and nurses and other vital questions regarding the proper handling of the insane. The underlying tone of the entire volume is to manage those under care with gentleness and kindness rather than by drastic measures. The non-restraint method of caring for the insane is a modern development, but is gaining additional adherents daily, thereby opening up a new regime in the treatment of insanity. Maryland has just passed through a transition in its method of caring for the insane, the State Lunacy Commission having ordered the abolishment of the strait-jacket, etc., in the State institutions, with marked benefit to the physical comfort of the patients, and so far no loss in control over the unfortunate individuals. Doctor Page, through his wide experience in managing the insane, is well qualified to speak as regards the non-restraint method in caring for the insane. What he says is said with the backing of twenty-five years' experience in this line of work. If, as he states, he has found the practical elimination of mechanical restraint a benefit and a blessing to the mentally unbalanced, surely others could employ the same measures with as much satisfaction. Remember the insane are sick people, as well as those suffering from appendicitis, and should command as much sympathy, kindness and care. Nobody can read the present volume without being convinced that in insanity as well as other ills the chief essential to success is humaneness.

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EPIDEMIC CEREBROSPINAL MENINGITIS. By Abraham Sophian, M.D., Formerly with New York Research Laboratory. Twenty-three Illustrations. St. Louis: C. V. Mosby Company. 1913. Cloth, $3.00 net.

This monograph of some two hundred odd pages is a distinct addition to our literature on this interesting infectious disease, as it is written by a man who is cognizant not only with the laboratory side but also the practical, he having had experience in the clinical laboratories of New York and in the field in Texas. It is an effort to stimulate further investigations, and thus increase our knowledge concerning this malady. The author, besides

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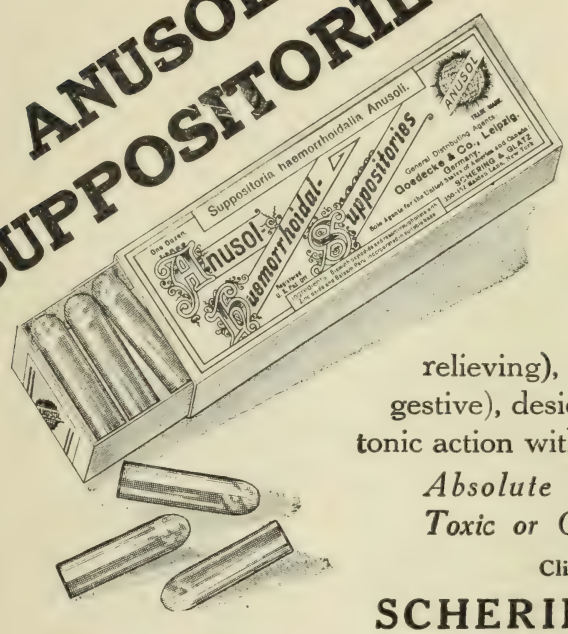


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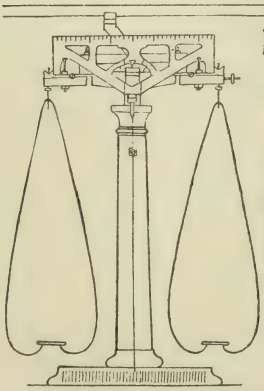

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entering thoroughly into its etiology, distribution, symptomatology, laboratory diagnosis, complications and treatment, especially emphasizes the methods to be employed in controlling an epidemic and the studies on blood-pressure in meningitis.

As a concrete example of the interdependence between laboratory and practice no more beautiful lesson could be adduced than the control of the Texas epidemic. Here all the laboratory theories and experiments were applied practically to the human individual, and the results gained thereby set forth in this book. The organism was not only regained from the cerebrospinal fluid, but also from the nasopharynx, and in the latter location was detected in some instances before the meningitis set in. The author was also able to prove that some people acted as carriers of the affection, and that it was useless to hope for a stamping out of an outbreak until these carrier cases have been recognized, properly quarantined and held in limbo until their throats cease to show the presence of the micro-coccus peculiar to epidemic cerebrospinal meningitis. The author minutely explains the operation of lumbar puncture, the position in which to place the patient, preparation of the site of puncture, route of puncture, level to be chosen, depth of puncture, dangers to look out for and other details of more or less interest, besides a condensed history of the introduction of the specific anti-meningitis serum, its preparation, standardization and prophylactic and curative uses.

As cerebrospinal meningitis of the epidemic form has and will occur in Baltimore and Maryland, it behooves the profession to be prepared to recognize it when it puts in its appearance, and to be fully acquainted with its treatment. As a reliable guide the above volume will be found to be admirably qualified. It treats the subject in a brief manner, still fulsome enough to meet the requirements of the active, busy practitioner, who is compelled through circumstances to get his information with as little loss of time as compatible with a thorough understanding of the disease under investigation. It gives us great pleasure to recommend this volume for that purpose.

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The Narcotic Drug Diseases and Allied Ailments. Pathology, Pathogenesis and Treatment. By George E. Pelty, M.D., Memphis, Tenn., Member Memphis and Shelby County Medical Society, Tennessee State Medical Association, Tri-State Medical Association of Mississippi-Arkansas-Tennessee; also Mississippi Valley Medical Association, Southern Medical Association and of the American Society for the Study of Alcohol and Narcotic Diseases. Illustrated. 1913. Philadelphia: F. A. Davis Company. Cloth, $5.00 net.

The profession is just beginning to realize that the habitues of drugs are the victims of disease and as such entitled to our commiseration, pity and help. In many instances those addicted to the use of opium, alcohol, etc., are the victims of circumstances over which they had no control. An intractable neuralgia calls for relief, the victim is beside him or herself with pain; the hypodermic syringe, after perhaps hours of suffering, gives the desired relief; after the influence of the drug wears off the pain recurs, maybe in a more aggravated form than before; the sufferer calls again for release from pain; another dose of morphia,

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and thus the habit, once started, gains greater and greater control over the user. Such is oftentimes the history one obtains from the narcotic victims. Under the circumstances is it fair to condemn these wretches? They are miserable enough already, and instead of condemnation, need sympathy and help. It is with this object in view that Pelty has written his book on the drug diseases. He treats the narcotic habit as it really is, namely, a disease, and as a disease he tries to impress upon the reader the importance of detecting the causative factor in the production of the habit. When one stops to consider the number who are addicted to one or another form of drug, one can only realize the value of Pelty's production, which treats the subject in a rational and scientific manner. Besides entering into the historical aspect of the subject, he also very fully and thoroughly depicts the symptoms of the user of opium, and the symptoms arising when the opiate is withdrawn, as well as the treatment. In the latter part of the book he devotes considerable space to the cocaine and alcoholic users, delirium tremens, and the treatment of acute ailments occurring in alcoholic subjects.

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Golden Rules of Diagnosis and Treatment of Diseases. Aphorisms, Observations and Precepts on the Method of Examination and Diagnosis of Diseases, with Practical Rules for Proper Remedial Procedure. By Henry A. Cables, B.S., M.D., Professor of Medicine and Clinical Medicine of the College of Physicians and Surgeons; Consultant at Jefferson Hospital; formerly House Physician at Alexian Brothers' Hospital, St. Louis. Second edition, revised and rewritten. St. Louis: C. V. Mosby Company. 1913. Cloth, $2.25.

The principal characteristic of the present edition, as of the first, is the brevity of statement and compactness of description of any given disease. This feature renders it possible for the busy practitioner to readily and quickly look up a subject with the least expenditure of time and energy. The present volume is full of useful hints and aids which the author has found of use in his practice. It is just the thing for quick reference, as it treats each subject with enough fullness to make it intelligible, but with sufficient brevity to meet the most exacting demands of a first-aid textbook. We predict for it as great a popularity as its predecessor, as it is written in the same simple diction, and the author has been fully alive to the necessity of keeping his statements in accord with modern medical thought. It is, therefore, entirely dependable for the purposes for which it is intended.

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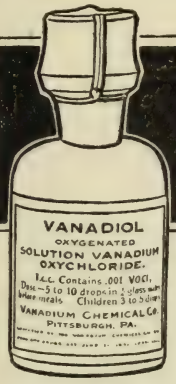
Tuberculin in Diagnosis and Treatment. By Francis Marion Pottenger, A.M., M.D., LL.D., Medical Director of the Pottenger Sanatorium for Diseases of the Lungs and Throat, Monrovia, Cal. With 35 illustrations, including one plate in colors. St. Louis: C. V. Mosby Company. 1913. Cloth, $3 net.

The status of tuberculin in diagnosis and treatment has been frequently written upon, but with more or less indefinite results when it comes to the purposes of the general reader, who before he finishes the article is lost in a haze of intricacies. Still much has been learned of the uses of this agent of late both by experi-

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mentation upon the animal and observation upon the man. It is therefore proper that Dr. Pottenger, who has had an enormous experience with this drug, present his conclusions to the medical profession, so that the great body of general practitioners be in a better position to judge of its uses. This monograph of a little over 200 pages is devoted entirely to the various phases of tuberculin in diagnosis and treatment as found useful and beneficial in the hands of Dr. Pottenger. It is a book that should be in the hands of every general practitioner, as it minutely and accurately describes the technique when using tuberculin and those cases in which it may be looked for to do good. In the hands of Dr. Pottenger it has given excellent results; consequently he may be a little overenthusiastic. Withal he speaks very conservatively, and does not lead one to believe that it is a cure-all in this most dreaded of diseases. After a careful perusal of the pages of the above volume one will be in a much better position to understand the uses of tuberculin in diagnosis and treatment of tuberculosis. We take pleasure in commending it to the medical profession.

---

A Compend on Bacteriology, Including Animal Parasites. By Robert L. Pitfield, M.D., Pathologist to the Germantown Hospital; Late Demonstrator of Bacteriology at the Medico-Chirurgical College, Philadelphia; Visiting Physician to St. Timothy's Hospital and Chestnut Hill Hospital, Philadelphia. Second edition, with 4 plates and 85 other illustrations. Philadelphia: P. Blakiston's Son & Co. 1913. Cloth, $1 net.

This little book is exceptionally well adapted to the needs of the student when used in conjunction with larger textbooks. It is also exceptionally suited to graduates when preparing for examinations, either school or State boards. Though spoken of as a compend, it is really a little textbook; though brief, still it contains the essentials, and a person well grounded in the elements of bacteriology will find it a useful guide for the purposes mentioned above.

---

Ophthalmology for Veterinarians. By Walter N. Sharp, M.D., Professor of Ophthalmology in the Indiana Veterinarian College; Ophthalmic Surgeon to the Indiana City Hospital. 12mo, 210 pages; illustrated. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. 1913. Cloth, $2 net.

Here is a book every veterinarian should possess. It is practical, written in an easy style and handsomely illustrated, some of which are in colors. From every aspect it is excellently gotten up, and every practitioner of veterinary surgery should become thoroughly familiar with its contents. It takes up in a systematic manner the anatomy of the eye, examination of the eye, diseases of the lids, operations on the lids, diseases of the lachrymal apparatus, muscles of the eyeball, diseases of the conjunctiva, diseases of the cornea, diseases of the iris and ciliary body, diseases of the retina and choroid, diseases of the optic nerve, diseases of the lens, operations for cataract, recurrent ophthalmia, glaucoma, injuries of the globe, fracture of the orbit, parasites of the eye, the principles of

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vision, errors of refraction, medicines used in ophthalmic treatment.

The book is principally based upon the course of lectures delivered by the author to the senior class of the Indiana Veterinary College, and lays especial emphasis upon external diseases of the eye, as these diseases are the principal eye affections attacking animals. We are especially pleased to see a book of this character, as it shows a trend toward a better and more scientific education of the veterinarian. It is such books which awaken a pride in a profession and points out the way to its elevation into a higher and fuller usefulness.

---

Solidified Carbon-Dioxide. In the Successful Treatment of Cutaneous Neoplasms and Other Skin Diseases, with Special Reference to Angioma, Epithelioma and Lupus Erythematosus. Fully illustrated. By Ralph Bernstein, M.D., Philadelphia, Pa., Clinical Instructor in Skin Diseases, Hahnemann Medical College, Philadelphia, Pa.; Consulting Dermatologist to the Women's Southern Homeopathic Hospital, Philadelphia, Pa.; Consulting Dermatologist to the J. Lewis Crozer Hospital and Home for Incurables, Chester, Pa.; Consulting Dermatologist to the House of Detention for Juveniles, Philadelphia, Pa.; Dermatologist to West Philadelphia General Homeopathic Hospital and Dispensary; Dermatologist to Hahnemann Hospital Dispensary, Philadelphia, etc. 1912. Cloth. Hammond, Ind.: Frank S. Betz Company.

The appearance of this booklet is indeed timely, as lately a great deal of interest has been aroused in the medical profession as regards the uses to which the carbon-dioxide snow can be put to and how to employ it. That it is a valuable agent in the removal of skin blemishes of one sort or another has now become generally accepted, but there are yet many who do not know how to get it or how to employ it even if they have any at hand. This little book supplies that deficiency. It gives full and explicit directions in what cutaneous diseases it is valuable, and, of more importance to the practitioner, how to apply the snow. Added interest and usefulness is given to the book in that the author includes the reports of a number of cases treated by him by solidified carbonic acid. It will be found by the general practitioner a handy book to have around.

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The Surgical Clinics of John B. Murphy, M.D., at Mercy Hospital, Chicago, June, 1913. W. B. Saunders Company, Philadelphia and London. Baltimore: The Medical Standard Book Company. Published Bi-Monthly. Paper, $8 per year.

The present number of Murphy's Clinics is up to the standard of its predecessors. In fact, it contains a greater wealth of material than a number of its predecessors. In this number are to be found discussions by one of the greatest surgical teachers in the world of his methods in the treatment of bony ankyloses, dislocated cartilages, procidentia uteri, cholecystitis, bone fractures, arthroplastics, tenoplasty, etc., and the operation of bone grafting for the cure of Pott's Disease, as devised by Dr. F. H. Albee, of New York City, including a talk by Dr. Albee at Mercy Hospital Clinic.

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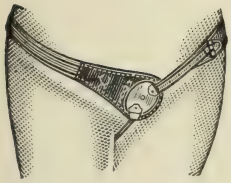

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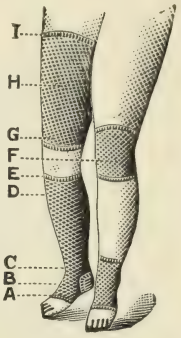


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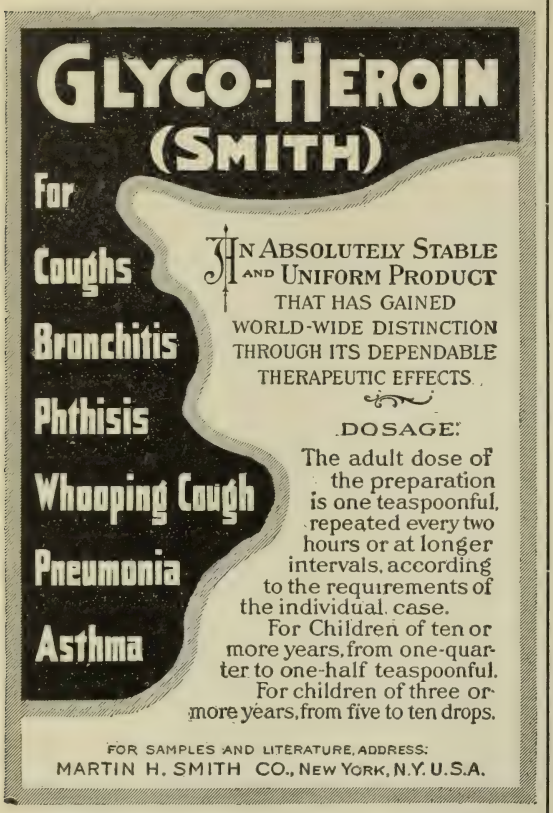
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# Book Reviews.

BLOOD PRESSURE. FROM THE CLINICAL STANDPOINT. By Francis Ashley Faught, M.D., Formerly Director of the Laboratory of Clinical Medicine of the Medico-Chirurgical Hospital; Instructor in Medicine at the Medico-Chirurgical College, Philadelphia. Octavo of 281 pages; illustrated. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Company. Cloth, $3 net. 1913.

The value of knowing the blood pressure in cardio-vascular diseases has become so thoroughly inculcated in the profession that the appearance of a moderate size book upon the subject by such an authority as Faught is indeed opportune. Here, as in other lines of medicine, the findings of the sphygmomanometer is valueless unless they can be intelligently interpreted by the investigator. It is for this purpose that the present volume has been issued to the profession. Though of but comparatively few pages, it contains the gist of our present knowledge of the variations of the blood pressure in disease as learned clinically and experimentally. The author has added materially to the value of the book by devoting considerable space to a discussion of the circulation and its relation to blood pressure and the various methods employed in sphygmomanometry.

One only realizes the immense strides made in this feature of medical investigation when one stops and recalls that as recent a period as 1900 our knowledge of sphygmamonometry was of uncertain value, while today practically every doctor is taking the blood pressure with one sort or another apparatus. These strides have been enormous. The writer records this development truthfully and faithfully, and there is no one living who is better prepared to do so, as Faught took a prominent part in placing the science upon a firm basis. It is a book that no practicing physician should be without. Is moderate in price, so within the reach of all, and, better still, contains a wealth of information which is of practical service to the doctor.

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KEEN'S SURGERY: ITS PRINCIPLES AND PRACTICE. By Various Authors. Edited by William Williams Keen, M.D., LL.D., Emeritus Professor of Surgery and of Clinical Surgery, Jefferson Medical College, Philadelphia. Volume VI. With 519 Illustrations, 22 of Them in Colors. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. 1913. Octavo of 1177 Pages. Entire Work Consisting of Six Volumes. Per Volume, Cloth, $7 net; Half Morocco, $8 net.

Everybody remembers the anxious anticipation with which the first five volumes of Keen's Surgery was looked forward to, and its prompt and immediate success. It was not thought at that time that there would be a near need for revision, but so many changes have taken place in even so short a period that it was necessary to either completely rewrite the volumes, or what to the editor seemed a better plan, incorporate in a new volume our additions to surgical knowledge. Having decided upon this method of procedure, the editor with the same care and wisdom with which he selected his co-operators in the previous volumes did

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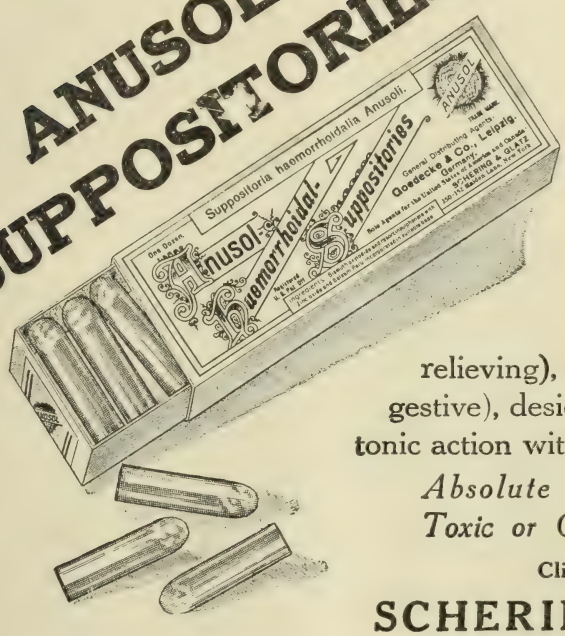


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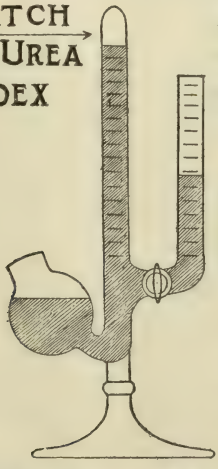

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the like by the sixth. Therefore in the present volume one gets at the least possible expense a complete review of those additions worth while which have appeared since the sister volumes were given to the profession, together with a general index to complete work.

Among the more important of the additions may be mentioned the important chapter on Anoci-association, a fuller description of apparatus for operating on the thorax and its contents under positive and negative pressure, the method of anesthesia of Meltzer and Auer by intratracheal insufflation, the newer methods of anesthesia by nitrous oxid and by the intravenous introduction of ether; surgery of the hypophysis, the treatment of cancer by fulguration, desiccation, etc.; the use of iodine as a disinfectant of wounds and of the field of operation, salvarsan in syphilis, the researches of Wassermann on mouse cancer, etc.

If no other field of surgery were included, the section of the advances made within the past few years on the surgery of the thorax and its contents would be well worth the price of the volume. Here one is given explicit directions how to operate under either positive or negative pressure, the advantages of the one over the other when such exists, and a resume of the practical application of the method in surgery upon man; so that today the last portion of the body yield to man's inquisitiveness has been brought within the pale of direct inspection whenever conditions demand. It seems needless to state that those who already possess the first five volumes can hardly do without the supplement, as here one finds in one volume those additions to surgical thought and practice.

---

Accessory Sinuses of the Nose. Catarrhal and Suppurative Diseases of. By Ross Hall Skillern, M.D., Professor of Laryngology, Medico-Chirurgical College; Laryngologist to the Rush Hospital; Fellow of the American Laryngological, Rhinological and Otological Society; Fellow of the New York Academy of Medicine; Member of the Society of German Laryngologists, etc., etc. Philadelphia and London: J. B. Lippincott Company. 1913. Cloth, $5 net. Illustrated.

"Accessory Sinuses of the Nose" is a book of decided merit and destined to be consulted by students, general practitioners and specialists as a guide and authority on the diseases, diagnosis and treatment of affcetions of these air spaces. Heretofore the student was compelled to go to general textbooks for information concerning diseases of these air spaces, consequently the knowledge obtained was, as a rule, superficial and incomplete. This book, therefore, fills the void in this branch of medical literature. It is well written, the style clear and lucid, and, above all, the contents based upon accurate and scientific observations by the author. The illustrations are numerous and well executed, the type large and clear, and the text remarkably free of typographical errors. Part one is devoted to general considerations, in which the author minutely describes the technique of examination of the nose for sinus disease, the anatomy of the lateral wall, the development of the accessory sinuses, physiology, bacteriology, pathological changes in the mucous membrane of the sinuses, unusual pathological complications of chronic inflammation, symptoms of sinus inflammation, laryngeal affections, pharyngeal affections,

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diagnosis, including transillumination, Roentgen ray and suction, treatment of the disease itself and its complications; part two to the anatomy, etiology, sequelae, diagnosis, symptoms and treatment of affections of the maxillary sinus; part three to the frontal sinus; part four, ethnoid labyrinth; part five, sphenoid sinus.

Owing to the relative greater frequency of these diseases, or, at any rate, their more frequent recognition, the book is indeed an addition to medical literature of great value. As a matter of fact, only after it comes to be better known will its true value be fully appreciated.

---

The Surgical Clinics of John B. Murphy, M.D., at Mercy Hospital, Chicago, April, 1913. Published Bi-Monthly by W. B. Saunders Company, Philadelphia and London. Baltimore: The Medical Standard Book Co. Paper, $8 per year.

Every physician, especially surgeon of any pretension, knows the worth of Murphy's Clinics, and it seems useless to try to impress upon them the necessity of receiving it regularly. If, however, there is one who does not think it necessary to his equipment, a careful perusal of any one volume since its first appearance will convince him that there are many points contained therein which are of practical use daily. The present issue contains such subjects as talks upon Essential Hemorrhage of the Uterus, Hysterectomy, with a full description of Murphy's Method for Hysterectomy; Pyloric Ulcer with Hyperthropy of Stomach Muscle; Duodenal Block (Result of Adhesions Following Attempted Perforation of Ulcer); Active Duodenal Ulcer Near Pylorus—Bleeding About Seven Hours Before Operation—A Few German Statics on the Button; Gastric Ulcer, a Talk by Mr. Robert Milne, F.R.C.S., of London; Recurrent Appendicitis, Retrocecal Appendix with Description of Murphy's Proctoclysis, etc., etc., the et ceteras being of as great interest as any of the subjects mentioned.

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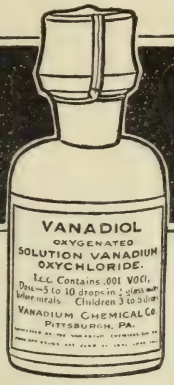
Massage, Manual Treatment, Remedial Movements, History, Mode of Application and Effects; Indications and Contra-indications. By Douglas Graham, M.D., Consultant and Instructor in Massage, Boston, Mass.; Member of the American Asociation for the Advancement of Science; of the American Medical Association; the Massachusetts Medical Society, etc., with a Chapter On Massage of the Eye by Dr. A. Darier, Paris, formerly President of the Ophthalmological Society of Paris; Chevalier of the Legion of Honor, etc. Fourth Edition, Rewritten and Enlarged. Seventy-five Illustrations. Philadelphia and London. J. B. Lippincott Company. Cloth. 1913.

The subject of massage is here considered by a well-trained doctor, who is in a position, by education and training, to weigh well its various features, and thus to give a scientific accounting of its physiological actions, and what, and what cannot, be expected of it along the line of treatment. Undoubtedly massage could be used to good advantage by the regular doctor, if he only knew what to expect of it, but, unfortunately, our school authorities as yet have not been awakened to the necessity of supplying this deficiency in their course, so the student leaves the college

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with only a hazy idea about massage, and in most instances that it is practiced by masseurs, chiro-practice or other ilk cults alone. Such an impression should be corrected, and students should be thoroughly drilled in mechanico-therapeutics, as they will find such agents of material benefit after leaving college. In the above-mentioned book Graham not only shows the place of massage in medicine, but he also performs the additional service of placing it upon a scientific basis. His labors will have the tendency to impress the profession of its woeful lack of knowledge in this art, and to awaken an interest in the subject. It is well written, full of humor, never for one moment dry, full of useful hints, excellently and scientifically arranged, and most minute when describing technic.

---

Textbook of Diseases of the Nose, Throat and Ear. For the Use of Students and General Practitioners. By Francis R. Packard, M.D., Professor of Diseases of the Nose and Throat in the Philadelphia Polyclinic Hospital and College for Graduates in Medicine; Aurist to the Out-Patient Department of the Pennsylvania Hospital. Second Edition 145 Illustrations. 1913. Philadelphia and London: J. B. Lippincott Company. Cloth, $3.50 net.

If you know anybody about to purchase a textbook on diseases of the nose, throat and ear, by all means advise him to buy Packard's. It is up-to-the-minute in arrangement, scientific treatment of the subject, diagnosis and treatment of the affections with which it treats. Here the student will find the elements of rhinology, otology, laryngology, in an attractive and easily assimilable form. In fact, in such form as to enable him to apply the knowledge thus learned to practical purposes when brought face to face with disease. We are particularly pleased with the elimination of abstract complicated theories and the pages devoted to what is reasonably well proven. This feature will, as heretofore, render the book attractive to seeker for the practical. It gives us great pleasure in recommending the second edition of Packard's Text-Book of Diseases of the Nose, Throat and Ear to our readers.

---

The Tonsils and the Voice in Science, Surgery, Speech and Song. A Comprehensive Monograph on the Structure, Utility, Derangement and Treatment of the Tonsils, and of Their Relationship to Perfect Tone Production. A Research Study With Original Contributions from the Highest Medical and Voice Authorities. By Richard B. Faulkner, M.D. (Columbia University), With an Introduction by Professor George M. Sleeth, Instructor in Elocution, Western Theological Seminary. Pittsburg, Pa.: The Presbyterian Book Store.

Physicians have the questions put to them on every hand, What is the function of the tonsil? If it serves no useful purpose, why is it placed in the body? Does its removal affect the voice in singing or talking? These and many other questions of a scientific nature have never been satisfactorily explained. In fact, those questioned have dismissed the query with an offhand reply, fully realizing that the explanation would not stand the strong light of scientific scrutiny. Faulkner is the first, so far as we are aware,

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who has attacked the subject in a scientific manner. He has not only treated the subject from a medical standpoint, but has also interwomen the opinions of the voice masters as to their ideas concerning the mechanical part played by the tonsil in the production of the voice. After describing what he considers a normal tonsil, not only from his own ideas as to what should constitute a healthy tonsil, but also as gleaned from the replies of numerous authorities, together with a description of the anatomy, histology, special anatomy and surgical anatomy, the author proceeds to a discussion of the physiology of the tonsil, of which the author states some are settled, the judgment upon others so uniform as almost to force conviction, and some unsolved. It is known that the ensemble of adenoid bodies composing Waldeyer's ring, situated at the entrance of the respiratory and digestive passages, constitutes the first line of defense against microbic invasion. The author is of the opinion that it is a vital mistake to remove an hypertrophied tonsil when at its height, as it is at this period that the process of phagocytosis through the tonsil is most active and represents its height of bacterial energy. However, with the sterility of biological and physilogico-chemical laboratory research, pertaining to the function of the faucial tonsil, the author questions the wisdom of classifying this origin as a component part of the Waldeyer ring, because,

(1) It lacks the most ordinary and essential features of the lymphatic structures, and of the tonsils that compose the ring.

(2) It possesses important mechanical, acoustic and phonetic functions which are not possessed by any other body of the ring.

Then stating that in no medical book can the mechanical defects of the tonsil be found, the author proceeds to demonstrate that (1) The faucial tonsil plays an important role in the mechanism of voice production. (2) The misuse of the voice by an incorrect method in singing or speaking acts in a mechanical way in causing enlargement, or disease, of the tonsil. (3) Tonsils enlarged, or diseased, through a wrong method of voice production, may be cured by the substitution of a correct method. (4) Tonsils that are swollen, tender and painful, caused by the misuse of the voice, will in turn, by their abnormal condition, hinder the proper action of the voice mechanism, and this hindrance will be relieved by proper use of the voice. (5) Removal of the normal faucial tonsil interferes with the mechanism of the voice. (6) The presence of the faucial tonsil being essential as a factor in voice mechanism, its absence necessarily interferes with the perfect action of mechanism and is necessarily inimical to the formation of a good singing or public speaking tone. (7) The mere absence of the normal faucial tonsil impairs and weakens—and the presence of adhesions, scars and contractions incidental to its removal, interferes with—the mechanism of the voice. According to the authorities quoted, vocalists on the whole depreciate the total removal of the tonsils, while medical men approve, though there are some notable exceptions. The entire tenor of the volume is to emphasize the crossing signal, stop, look, listen before tonsillectomy, as much damage may result thereby, and that tonsillectomies are not the panaceas which they have been painted. It is an able dissertation, along unique lines, based upon scientific facts, facts which, if better known and understood by the profession, would check the indiscriminate massacre which is now the approved practice.

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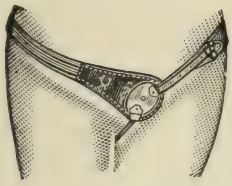

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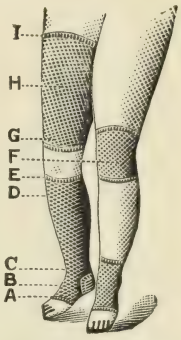


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THIS Directory is maintained mainly for the benefit of local firms seeking the patronage of physicians and their families. Only well established and reliable concerns will be represented, and doubtless the space at our disposal will be constantly in demand. In responding to these exploitations, the reader will find it mutually advantageous to mention the MARYLAND MEDICAL JOURNAL.

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HARDLY another of all the preparations in existence offers a wider scope to imposition under the plea of "just as good" than the scientifically standardized Eucalyptol.

The most recent fraud practiced in regard to this product is an attempt to profit by the renown of the firm of Sander & Sons. In order to foist upon the unwary a crude oil, that had proved injurious upon application, the firm name of Sander & Sons is illicitly appropriated, the make-up of their goods imitated, and finally the medical reports commenting on the merits of their excellent preparation are made use of to give the desired luster to the intended deceit.

This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

### Estimating a Drug's Merit.

IN estimating the merit of Bromidia (Battle) the features that should receive full consideration are its definite therapeutic potency and its freedom from the production of disagreeable after-effects, which latter, unfortunately, so frequently tend to neutralize the therapeutic efficiency of extemporaneously prepared bromide mixtures.

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been gained through its meeting severe clinical demands.

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**The Advantages of an Elm Poultice.**

THE value of topical applications of glycerine has long been recognized in certain skin diseases. Chemically pure undiluted glycerine, however, is somewhat irritant, but its action is soothing and curative as used with elm wool in Glyco-Ulmus, Lilly. These two ingredients combined with phenol and methyl salicylate, which favorably modify pathogenic processes in the skin, stimulate the local blood supply, and therefore improve nutrition, and meanwhile the elm wool serves its purpose as an absorptive in the reduction of serious accumulations and local inflammations. Such a combination as the above is prepared at the Lilly Laboratories and sold through drug channels under the descriptive label, Glyco-Ulmus, Lilly. It has the advantage of being much lighter than kaolin dressings and contains more glycerine. For this reason it is particularly adapted in pneumonia cases. If used early on boils, suppuration, it is said, will not occur. It is cleaner and much easier to remove than the kaolin dressings. Glyco-Ulmus, Lilly, is supplied in six-ounce and one-pound glass jars.

---

**Clinical Results with the Phylacogens.**

UNDER the above caption Dr. R. W. Locher, Grafton, W. Va., in the *Memphis Medical Monthly*, has this to say: "In judging the therapeutic value of a new preparation it is advisable that a great number of case reports be considered, and in order that the medical profession may have a great number of cases from which to judge it is the duty of every physician to report such results as he may have. The Phylacogens are of comparatively recent origin, and yet even at this early date they have displayed their ability to produce satisfactory, and in some cases remarkable, results in the treatment of a great variety of pathological conditions. * * *

"We are informed that the Phylacogens are not claimed to be a 'cure-all' in any sense of the word, but simply valuable therapeutic agents in the treatment of numerous infectious conditions. From the very fact that all but Mixed Infection Phylacogen are to be directed against specific infections, it is necessary, before employing them, to make an accurate etiological diagnosis. For obvious reasons one cannot expect to produce results if Rheumatism Phylacogen is administered in a case that is really one of gonorrheal arthritis. Neither will an osteomyelitis or a syphilitic periostitis yield to Rheumatism Phylacogen, but the former may be logically treated with Mixed Infection Phylacogen. It would seem that this latter Phylacogen will ultimately prove of great value to the surgeon in combating post-operative infections, as well as infections following injuries of all kinds."

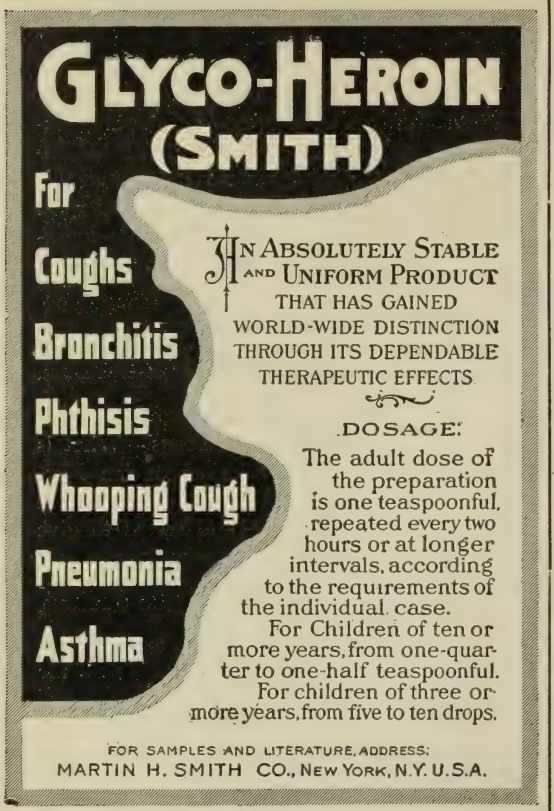
The writer then details 14 case reports, covering a variety of diseases, and adds this by way of comment:

"From the foregoing cases it would be possible to draw numerous conclusions. What is especially striking, however, is that the Phylacogen treatment is apparently successful in the vast majority of cases, and seems to give prompter and more definite results than is possible to secure with the usual recognized treatments. As a physician's experience increases he finds a greater number of cases in which each of the Phylacogens may be used, with the expectation of great benefit resulting therefrom. In any event it must be conceded that Phylacogen in its various forms presents great possibilities and must be classed as a therapeutic agent which is more than worthy of trial."

---

**The Test of a Tonic.**

THE field and function of a systemic tonic is generally understood and appreciated by both physician and patient. To stimulate, whip or goad the vital processes is not to "tone," but, on the contrary, to ultimately depress. A real tonic is not a mere "pick-me-up," but some agent that adds genuine strength, force and vigor to the organism. The genuine tonic is a builder or reconstructor of both blood and tissue. Any agent which will increase the power of the blood to carry and distribute the life-giving oxygen is a tonic in the best and truest sense of the word. Iron in some form is an ideal tonic, as it builds up the vital red cells of the blood and the hemoglobin which is their essential oxygen-carrying element. Of all forms of iron, none is quite as generally acceptable and readily tolerable and assimilable as Pepto-Mangan (Gude). It creates appetite, tones up the absorbents, builds the blood, and thus is a real tonic and reconstructive of high order. It is especially desirable because of its freedom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**For Men, Women, Children and Babies.**

A MEDICAL writer a short time ago called the attention of his fellow practitioners to the large number of untoward conditions resulting to the human race from the erect posture. From a superficial point of view, this might be considered almost as a joke, but those who are familiar with the real facts would fail to see anything in it in the nature of a joke.

The fact is that a great many disabilities of varying importance are due almost exclusively to the erect posture. The old system was to temporize, and alleviate the various unfavorable symptoms with internal medicines, or, in some cases, by surgical procedure. It has been found, however, that a great deal can be accomplished by the use of the abdominal supporter or binder, but it requires a very accurate knowledge of anatomy to make these deductions. Dr. Katherine L. Storm has earned the appreciation of a great many prominent physicians and surgeons by her remarkable skill in correcting some of these mistakes made by nature.

It is seldom one's good fortune to develop proficiency exactly along the lines in which nearly everyone else is a novice. There are so many clumsy and disappointing ways of treating relaxed sacroiliac conditions, for instance, that Dr. Storm's method of doing it all with a supporter recalls the Columbus egg story. Another gratifying result was the application of this principle to the alleviation of the symptoms associated with pertussis, while with the hernias it has proved a great success.

It is hardly a stretch of imagination to speak of Dr. Storm's binder as an "old reliable." It is certainly so regarded by a large number of physicians in the city in which she is best known.

Such physicians at a distance who might like to know more of Dr. Storm's ability along this line should send for her booklet, which will tell what she can do for their patients, and at the same time show how she is regarded by those physicians who know her best.

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with many physicians, based on accurate observation and scientific deduction, that coffee, as a routine daily beverage, causes more or less serious disturbance in the nervous system of many persons.

The amount and degree of this disturbance may not be appreciable for a time in some who are able—perhaps for years—to withstand the over-stimulation of the nerves and heart induced by the regular ingestion of *caffein*—the coffee drug.

The observing physician detects what the layman does not always observe, and he knows that "coffee-heart" is as common in both men and women as "tobacco heart" is in men.

This condition is met in daily practice, and the physician —better than any one else—knows the quick improvement which should follow when coffee is interdicted and the pure food-drink **Postum**—free from any drug—is used instead.

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# Abstract.

ABSTRACT of paper read at the Minneapolis meeting of American Medical Association, June 17 to 21, on "The Results of Tonsillectomy Under Local Anesthesia," by Bryan De Forest Sheedy, M.D., of New York.

All of the 100 cases reported upon by the reader of the paper were examined several months after operation, and no patient under 14 years of age was operated upon under local anesthesia. There was no grouping of the patients examined as to whether the throat conditions were the result of operation under local or general anesthesia. The enucleation of the tonsils had been performed by some one of the many methods in vogue for the last few years for the complete removal of the gland, and as the operations were performed in practically all the public institutions in New York city, many men of prominence in laryngology were the operators, so that the results could not be attributed to poor technique on the part of one man.

The writer arrived at the conclusion that tonsillectomy, so far as removing pathological tonsils is concerned, is a better operation than the old-time tonsillatomy, but pointed out that many of the throat defects following the operation of enucleation are due to clumsy and non-surgical technique.

The writer also pointed out the normal relation of the surrounding parts to the tonsil, and put up a strong argument against the use of sharp instruments for the dissection of the tonsil from its bed, that being the cause of injury to the muscles, with resulting deformities.

Of the 100 cases examined months after operation, more than 80 per cent. of the patients had deformed throats. The 20 per cent. of patients with what appeared to be normal throats following the operation were inconvenienced in no way at any time following the operation. Of the 80 patients, 34 complained of speech defects for from one to three weeks after operation, 16 complained of speech defects for more than three months after operation, while four had practically lost the singing voice. About 25 per cent. of the patients stated that their throats felt better and that they could speak and sing better after operation than before. Inability to use certain words had continued with 5 per cent. of the patients for more than six months after operation.

The variety of deformities following enucleation were classified as follows:

(1) The pillars on both sides had disappeared, with the soft palate tightened to such an extent that the opening at the nasopharynx was narrowed.

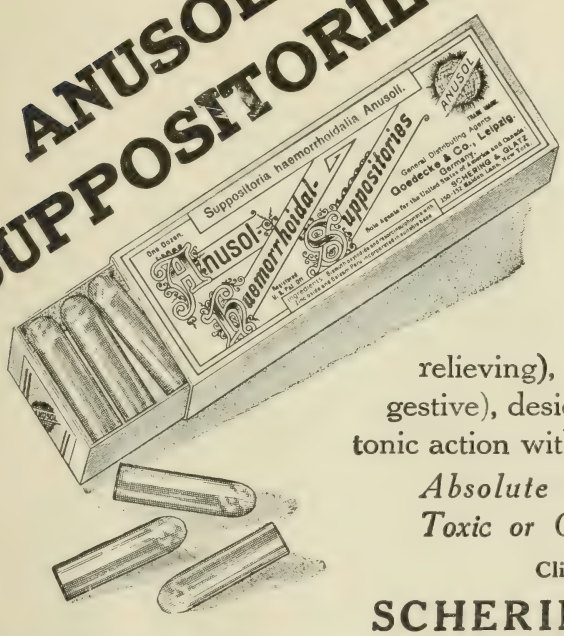
(2) The pillars on both sides had grown together.

(3) The anterior pillar had wholly disappeared, with a large amount of cicitricial tissue deposited on the posterior pillar.

In the four patients whose singing voice had been seriously affected, the posterior pillar had disappeared through amalgamation with the anterior or with the lateral wall of the pharynx.

The reader emphasized the fact that he did not think the last word had been said in regard to tonsil enucleation, and proposed as a remedy for preventing the unsatisfactory throat results an operation for removing the tonsil by what he called the "eversion

# ANUSOL SUPPOSITORIES

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method," and with charts and diagrams pointed out that the capsule of the tonsil is simply a bag, the bottom of which may be pulled through its mouth, so that its inner surface becomes the outer, and that if the capsule, with its glanular tissue, is everted and a snare placed on, removing the tonsil with its capsule complete (there being no dissection and, therefore, no injury to the muscles surrounding), there would be no deformities.

The exceptions to the rule presented, viz., that the tonsil will evert on traction, were:

(1) Those cases in which the capsule was bound down to the surrounding tissues by previous attacks of inflammation.

(2) Those cases where the capsule was very much contracted and contained cicitricial tissue only.

(3) Those cases of hypertrophied tonsils which had everted themselves and the tonsil was found everted when the patient applied for treatment.

The points advanced in favor of the procedure were:

(1) Simplicity of the operation.

(2) Practically no hemorrhage.

(3) Little or no deformity following the procedure.

(4) Only three instruments necessary for the operation, viz., tonsil tenaculum, blunt-pointed tonsil knife, Tyding snare.

## *Editorial Comment.*

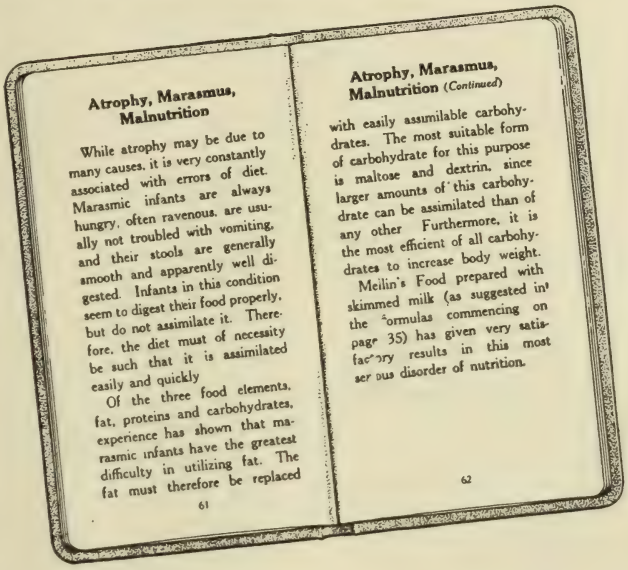
### ANTI-TYPHOID INOCULATIONS.

*The Journal of the Michigan State Medical Society.*

We have every reason to be proud of the record established by the Medical Corps of the United States Army in the prevention of typhoid fever. Ours is the only army in the world in which the use of anti-typhoid vaccine is made compulsory for every soldier under 45 years of age. The three inoculations used in our army insure a greater and more lasting immunity than do the two injections used in other countries. Major F. F. Russell, in a lecture before the Harvey Society in New York, February 8, 1913, says: "The immunity which three injections of the anti-typhoid vaccine now in use confers is equal to and identical with that conferred by an attack of the disease, and it can be obtained without danger and practically without the likelihood of distressing symptoms of reaction." The following statistics, given by Major Russell, show its success: In 1898, in 10,000 troops stationed at Jacksonville, there were over 1000 cases of typhoid, and 87 per cent. of the total deaths were due to typhoid. In 1911, in the army stationed in Texas—with anti-typhoid inoculation in general use—there were only two cases of typhoid fever and no mortality. In 1912 there were only 15 cases of typhoid in the whole standing army of 58,000 men, with only two deaths. Only one of these 15 had received the three protective inoculations.

In the light of these results anti-typhoid vaccine should be more extensively used in civil life to protect physicians, nurses and others serving in hospitals where typhoid cases are admitted, and to immunize the remaining members of a family in which typhoid fever has appeared. In view of the fact that in several epidemics the infection has been carried by milk, it has been very aptly sug-

# Marasmus—



**Atrophy, Marasmus, Malnutrition**

While atrophy may be due to many causes, it is very constantly associated with errors of diet. Marasmic infants are always hungry, often ravenous, are usually not troubled with vomiting, and their stools are generally smooth and apparently well digested. Infants in this condition seem to digest their food properly, but do not assimilate it. Therefore, the diet must of necessity be such that it is assimilated easily and quickly

Of the three food elements, fat, proteins and carbohydrates, experience has shown that marasmic infants have the greatest difficulty in utilizing fat. The fat must therefore be replaced

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**Atrophy, Marasmus, Malnutrition** (*Continued*)

with easily assimilable carbohydrates. The most suitable form of carbohydrate for this purpose is maltose and dextrin, since larger amounts of this carbohydrate can be assimilated than of any other Furthermore, it is the most efficient of all carbohydrates to increase body weight.

Mellin's Food prepared with skimmed milk (as suggested in the formulas commencing on page 35) has given very satisfactory results in this most serious disorder of nutrition.

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WHEN you write advertisers, mention the MARYLAND MEDICAL JOURNAL.

gested that all those handling milk, supplied particularly to large centers, be required to receive protective inoculations.

The most encouraging results yet obtained in the treatment of typhoid bacillus carriers have been through the use of vaccines combined with X-ray exposures in gall-bladder cases and hexamethylenamin in urinary cases.

Experimentally, it has been shown that no production of opsonins and agglutinins occur for from 5 to 11 days after the first injection; from that time on to the twenty-fifth day there is a very rapid production of anti-bodies. In the treatment of typhoid the immunity reaction has already been started by the existing infection, and the response is somewhat more prompt. Thus far vaccines have been used in 500 or more reported cases, and it is the general opinion that when used early and given in sufficient doses, the course of the disease is shortened, the symptoms are less severe, the death rate is lowered, and there are fewer complications and relapses.

## THE USE OF OIL OF ORANGE IN ANESTHESIA.

*The Journal of the Michigan State Medical Society.*

When the ether, employed in anesthesia, is combined with the oil of orange the patient may be anesthetized with less discomfort, with no preliminary stage of excitement, and with the consumption of about one-half the quantity of ether that is otherwise required; there is also a speedy recovery from the anesthetic state, without nausea or vomiting.

This was shown by Gwathmey[1] several years ago. In a recent publication we note that Jarvis,[2] after certain experiment, concludes: (1) That essential oil of orange enhibits nasal reflexes, elicited by ether alone; (2) the inhalation of the oil of orange previous to the inhalation of ether (for three minutes) suppresses the reflexes of dilatation of the lungs and stomach that is produced by ether vapor.

The technic of the administration is to allow the patient to inhale the oil of orange from the ordinary mask for a period averaging about three minutes before the commencement of the administration of the ether. When the ether vapor is commenced it is combined with the oil of orange vapor in the proportion of one ounce of the essential oil and one ounce of water contained in a separate bottle that is connected with the ether vaporizer.

If the above results are thus obtainable—and we have no reason to believe otherwise—it becomes essential that every person administering ether as an anesthetic should employ this adjuvant. Every method that has a worthy claim to being an agent that will enhance or reduce to a minimum the dangers that are connected with the production of the anesthetic state should be employed on every occasion where ether is exhibited as the drug of choice. Even though ether is conceded by the majority as being the safest anesthetic, it is our bounden duty to render it more safe if we can possibly do so.

We would recommend that Gwathmey's suggestion:[3] (1) The preliminary administration of morphin and atropin or some similar drug or combination; (2) commencing the anesthesia with

[1] *Jour. Am. Med. Assn.*, Dec. 17, 1901.
[2] *Month. Cycl. and Med. Bull.*, January, 1913.
[3] *Jour. Am. Med. Assn.*, Nov. 23, 1912.

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*SIG—One or two at bedtime.*

**For Constipation**

"An ideal purgative minus cathartic iniquities."

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*SIG—One to three pillets three times a day.*

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"A cardiac tonic of exceptional value when the heart needs supporting or reinforcing."

℞ **Seng** — One Bottle

*SIG—One to two teaspoonfuls in water before meals.*

**For Atonic Dyspepsia**

"A stimulator of glandular activity throughout the alimentary canal."

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two to four drops of the essence of orange (25 per cent., U. S. P.); (3) the drop method of anesthol until the patient reaches surgical anesthesia, and then a change to the drop method of "vapor anesthesia;" be used by those who are employing ether as their anesthetic agent of choice.

---

## NO CRUELTY IN PRODUCTION OF OSTRICH FEATHERS.

From countries other than South Africa come reports that the opinion is widespread that the production of ostrich feathers entails a considerable amount of cruelty to the birds. Attempts were even made to get ostrich feathers included in the bill for the prohibition of the importation of the plumage of wild birds into the United States. I desire to most emphatically state there is no cruelty attached to the production of ostrich feathers. The birds are driven into a small enclosure, and are caught one at a time. A sort of stocking is dropped over the ostrich's head when the creature at once becomes docile.

The plumes both of the tail and wings are snipped off with special clippers, the stumps of the quills being left in the sockets. These after a time shrivel naturally, and so all sensibility is lost; some drop out, and the rest are removed without the rupture of a single blood vessel. The whole process is absolutely painless—as much so as cutting one's finger nails in the usual manner.

No farmer would be stupid enough to actually pull out the plumes, for the reason that in so doing the cells within the socket, which build the substance of the feather, are more or less seriously damaged, causing the next and all succeeding crops of feathers to be inferior. Every farmer knows that the value of each ostrich is in proportion to the excellence of the feathers, and that market prices for these plumes are graded according to quality; therefore, the most brutal of ostrich farmers would never resort to plucking the feathers from the birds. The ostrich feather industry provides a living for millions of people, directly and indirectly, and my society considers that it is the duty of every S. P. C. A. to do its very best to educate public opinion on this matter.

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## THE EPIDEMIC OF BICHLORID POISONING.

*The Virginia Medical Semi-Monthly.*

At the present time an epidemic of poisoning by the bichlorid of mercury is surging over the country. Scarcely a day passes without the daily press record of one or more unfortunate accidents or suicides with this agent. Until the case of a Southern banker was recorded few were made public, but with the spectacular glamour surrounding the passing days of the victim, his reported statements that he suffered no pain, and that awaiting the final dissolution was pleasant, the pendulum has swung towards bichlorid.

Poisoning by bichlorid of mercury is fast supplanting carbolic acid, and for the education of those who desire to end life, the

# AN IMPORTANT REPORT

## By Professor W. A. Puckner

**Secretary of the Council on Pharmacy and Chemistry**
**American Medical Association**

In the Journal of the American Medical Association, September 13, 1913, Professor Puckner reports the result of the investigation of products of a number of pharmaceutical houses. In this report are embodied the results obtained by Dr. R. A. Hatcher, of Cornell University Medical School, who made a special examination of the various digitalis products of these pharmaceutical houses, demonstrating the following

## FACTS

**First.**—That commercial digitalis preparations vary most widely in activity.

**Second.**—That Mulford Digitalis, the most active, is four times as active as the weakest.

**Third.**—That the digitalis prepared by other firms, assumed to be physiologically assayed, showed a variation of more than 100 per cent in strength.

**Fourth.**—That the digitalis next in strength to the Mulford preparation, was only 65 per cent, and the weakest, 29 per cent in activity.

## CONCLUSIONS

While there is no official standard of activity for digitalis, Dr. Hatcher adopted the Mulford Fluidextract Digitalis as the standard of comparison, because its activity was that of a good digitalis. The report proves the activity and reliability of the Mulford Digitalis, and coincides with the former report made by the United States Bureau of Hygiene, tabulated in Bulletin No. 48, December, 1908, by Edmunds and Hale, relating to the Mulford Fat-free Tincture of Digitalis—**Digitol.**

No arguments are needed to convince the careful physician and druggist why they should demand Mulford Standardized Pharmaceuticals.

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number of tablets and number of grains contained are faithfully stated.

When poisoning results from accident, the reason assigned is mistaking the container for one with migraine, dyspepsia or other tablets.

It is hardly necessary to speak of the symptoms of these poison cases, or of the slow permeation of the system with mercury sometimes observed; our only purpose is to sound a warning. These cases rarely survive 10 or 12 days; usually they terminate in from half to several hours.

The time has arrived when severe restrictions must be placed upon the sale of this preparation; the simple registration of the sale, with the reason of the purchase, does not suffice. The label of the firm making the sale only serves for identification. The reasons for the purchase are usually false; therefore, the prescription of a regular registered physician must be demanded, as in the case of morphia, cocain and other poisons.

Nearly every obstetric outfit contains at least 25 tablets of bichlorid of mercury, and a majority of such cases will procure the outfit. In the hands of a responsible nurse, or an intelligent woman, little danger is apprehended during the lying-in; but when convalescence and good health is established, the unemptied container is placed among the other bottles in the medicine case, where it becomes a menace and a source of danger to the family. In the confusion and hurry of an emergency, which will usually occur during the night, the wrong bottle is seized, the patient given poison and a fatality is recorded.

Instances occur where no pain is complained of; but this absence of pain is not the rule—quite otherwise; it is due to the presence of food in the stomach, or to the compressed tablet dissolving slowly. In those cases where there is a slow solution of the tablet medical aid is generally powerless, and the unfortunate one may linger for days, to finally pass away. This may be proved by deaths following vaginal douches with the mercuric solution, continued for a long period.

Now, the question arises, who is to blame? It is useless to attempt to shift the responsibility to lax law, to the druggist, or to the individual giving the poison; the entire responsibility rests upon the physician in the case, since there can be no plausible reason advanced for leaving in the hands of the patient more of these tablets than the necessities of the case demand. Many obstetric cases are completed without the use of a single tablet, while the same may be said of many surgical cases.

Different sizes, shapes and color will occasionally alter the situation, but a white tablet must be deceiving.

The treatment of poisoning with bichlorid of mercury is to empty the stomach by emetics—apomorphia, mustard or a simple mixture; administer milk and the whites of eggs, but remember the albuminate of mercury thus formed must be removed, so that emetics will be again needed; give olive oil in plentiful quantity. The use of the stomach pump will be the decision of the medical attendant. If there is much corrosion a perforation may result. Freshly prepared hydrated ferrous sulphid is a positive antidote, but rarely on hand quick enough to be of service (Bouchardat).—*L. E.*

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# The Effect of Resinol in Typical Skin Diseases

*By J. H. Hurst, M.D., Indian Springs, Tenn.*

I have had many interesting cases of skin diseases come under my observation in which Resinol ointment has given excellent results. I have been prescribing this preparation for over fifteen years and beg to submit case reports of two typical instances of its successful use.

CASE 1.—Mrs. C., aged 58, came under my care suffering with a very aggravated case of eczema. The disease covered both hands and extended to about the elbows. It had continued over a period of something like six months and was one continuous eruption, giving excruciating pain, especially when getting the skin wet. It had been treated at home with various lotions, salves, etc., and by one very able young doctor, a friend of mine. The patient finally asked me to "try my hand at the case." The skin was first thoroughly softened with Resinol soap and dried. After this the Resinol ointment was thoroughly rubbed in every night and morning. *Itching ceased after the first application* and the case went on to rapid recovery, the skin being perfectly smooth in a week.

CASE 2.—Mr. James B. presented a marked case of tinea sycosis (barber's itch). Numerous remedies had been tried with only temporary relief. The disease had become chronic, covering a period of over two years. These cases are very hard to handle with ordinary treatment. I prescribed Resinol ointment, the skin being well softened by Resinol soap and hot water first. The Resinol ointment was used every night, on retiring, no shaving being permitted, but clipping the beard with sharp scissors. This treatment was entirely successful in about two weeks. After three years there has been no return.

NOTE.—While Resinol ointment has its largest application in the treatment of skin diseases, and especially in the speedy control of itching, yet its properties are such that it lends itself to a wide range of other uses. As a dressing for burns and scalds, ulcers, boils and similar lesions, for severe chafing, and for piles, it is convenient, uniform and efficient. Physicians wishing to test Resinol ointment and Resinol soap can obtain samples on application. Also ask for a miniature Resinol shaving stick.

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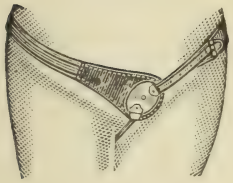

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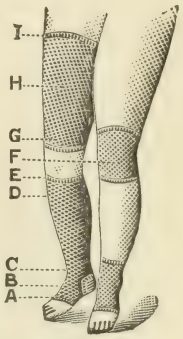


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### Danger Due to Substitution.

HARDLY another of all the preparations in existence offers a wider scope to imposition under the plea of "just as good" than the scientifically standardized Eucalyptol.

The most recent fraud practiced in regard to this product is an attempt to profit by the renown of the firm of Sander & Sons. In order to foist upon the unwary a crude oil, that had proved injurious upon application, the firm

name of Sander & Sons is illicitly appropriated, the make-up of their goods imitated, and finally the medical reports commenting on the merits of their excellent preparation are made use of to give the desired luster to the intended deceit.

This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

---

**Collargolum Continues to Be the Peferred Injection Medium in Skiagraphy and Uretero-Pyelography.**

While by far the greatest majority of American and European radiologists agree that Collargolum, which was first recommended by Voelcker and Von Lichtenberg in 1906 as the most advantageous injection medium into the bladder and renal pelvis, has not been equaled technically by any other material since suggested for this purpose, occasional reports of alleged injury from its use have recently appeared in the literature.

W. F. Braasch of the Mayo Clinic, St. Mary's Hospital, Rochester, Minn., who was the first to extensively apply Voelcker and Von Lichtenberg's technique in the United States, and has introduced many valuable modifications and diagnostic possibilities of the same, states in an article on "Recent Progress in Uretero-Pyelography" ( *Journal Mich. State Med. Soc.,* April, 1913) that this technique has been employed in the Mayo Clinic in more than 1000 cases without fatality or permanent injury. The occasionally observed colic following examination by this method was not more frequent nor more severe than after ureteral catheterization alone.

It has been his experience that severe reaction following pyelography is usually the result of errors in technique or lack of care in the selection of the cases. In regard to the latter, careful perusal of Dr. Braasch's article is strongly recommended to all those interested, a short abstract being inadequate to do justice to this part of his report.

The following technical precautions are urged by him:

The Collargolum crystals should be carefully ground in a mortar when put into solution (10 per cent.) and the latter filtered; otherwise undissolved crystals may be deposited on the walls of the pelvis and ureter and act as an irritant. The solution should be carefully warmed before injecting, not boiled, since it coagulates with boiling. The solution should be injected by the gravity method, watching the patient for the slightest evidence of pain. From 2 to 8 c.c. will usually suffice unless symptoms of obstruction have been previously noted. A large ureteral catheter should be used, so that the injected solution may drain away easily. The apparatus for the X-ray and the injection should be so arranged that there will be no delay after the catheter is inserted.

The unequaled diagnostic value of skiagraphy and utereo-pyelography by means of Collargolum and innocuousness of the method if carried out correctly is also vouched for by Dr. George H. Stover, professor of roentgenology, University of Colorado (*Annals of Surgery.* June, 1913); Dr. G. Strassmann of the surgical polyclinic of Prof. F. Voelcker, Heidelberg, Germany; Prof. Th. Nogier and Dr. J. Reynard of the University of Lyone (*Lyon Médical,* 1912, No. 51); Dr. William I. Bruce, radiologist to the Charing Cross and the Children's Hospital, London (*British Medical Journal,* October 14, 1911); Dr. E. M. Stanton, Schenectady, N. Y. (*Albany Medical Annals,* July, 1912); Dr. William T. Belfield, professor of genito-uninary surgery, Rush Medical College (*Journal A. M. A.,* March 15, 1912); Dr. Lewis G. Cole, clinical professor of radiology, New York Post-Graduate Hospital (*The Post-Graduate,* January, 1911); Dr. N. Nemenow, chief of Central Roentgen Laboratory, St. Petersburg Medical High School for Women (*Fortschr. auf dem. Geb. d. Roentgenstrahlen,* Vol. 18, No. 3), and by a constantly growing number of other reports from nearly every civilized country.

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**Bronchial Ailments of Elderly Persons.**

It is at this season of the year that persons well along in years demand of the physician an agent which will remedy a chronic bronchial inflammation so common in late years, and

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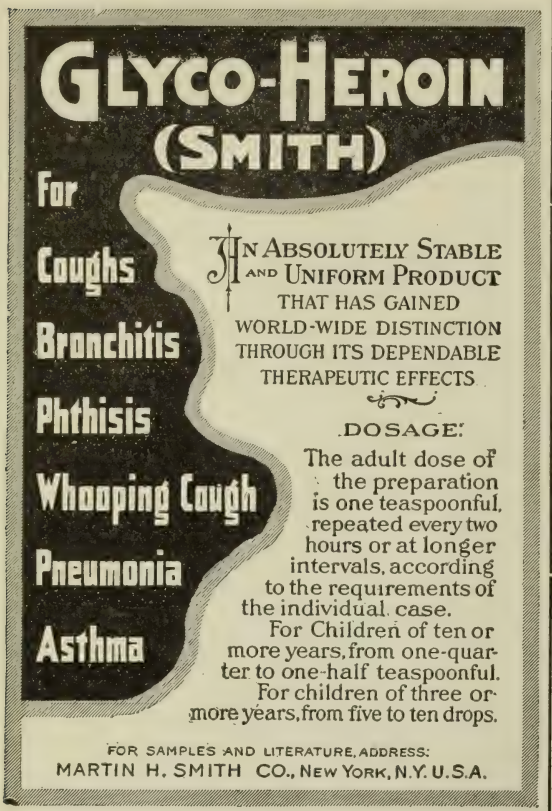
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which, as a rule, become especially distressing with the onset of cold weather.

An essential point to be considered in connection with the therapeutic needs of these cases is that whatever is ordered should serve the double purpose of acting as a sedative to the bronchial mucosa and as a nourishing agent to the tissues, without, at the same time, causing any disturbance of the normal functions of the gastric apparatus. The physician will find in Hagee's Cordial of the Extract of Cod-Liver Oil Compound an agent which meets these requirements clearly. Given to these old bronchial sufferers, this palatable preparation of cod-liver oil produces favorable results.

### An Alterative of Long Service.

It is mainly in chronic skin and glandular diseases that alteratives have found their most distinct field of usefulness, for these are conditions aggravated and continued by impaired nutrition and elimination, in the correction of which alteratives show what potent remedial forces they are. Among the alteratives Iodia (Battle) has long enjoyed professional favor, and in this will be found a striking demonstration of its value, for no class of drugs are put to a more rigid test than alteratives, so its long-continued use by physicians is the best evidence that it meets the demands made upon it. Iodia (Battle) will show its power in chronic skin diseases, glandular involvements and in other states indicating the corrective influence of an alterative agent. A distinct advantage offered by Iodia is that it may be continued over long periods without causing distress.

### A New Size Package of Platt's Chlorides.

An important move has been made by Henry B. Platt, manufacturer of Platt's Chlorides, the odorless disinfectant, by placing upon the market a small-size package to retail for 25 cents of this old reliable and well-known disinfectant that has been in general use for over 34 years by people of refinement in their homes and also in hospitals and other institutions.

The subject of household cleanliness and sanitation is now considered of vast importance, and more attention is being given to it by the health authorities all over the country. The general public are being advised to use disinfectants as a preventative of sickness, and the careful housewife now uses an efficient article that will safeguard her family.

Platt's Chlorides has been recommended by thousands of physicians in their general practice for many years. It is stronger than carbolic acid, safer to use, and, being absolutely odorless, does not cover one disagreeable odor with another.

The new 25-cent bottle will be of a more convenient size to handle, and will enable those housewifes who have never used Platt's Chlorides to give it a fair trial at a moderate cost. The regular large-size bottle with the yellow wrapper will still be put up to retail for 50 cents.

Advertisements will appear in the drug and medical journals, newspapers and magazines so as to create a demand for this new-size package.

### A Safe Sedative and Anodyne.

This is the language in which those who know its properties describe Pasadyne (Daniel). It is to be understood that Pasadyne (Daniel) is a distinctive name given to a concentrated tincture of passiflora incarnata which had been employed for a generation.

The specific value of Pasadyne lies in its marked sedative and analgesic powers and

freedom from evil effects. This feature at once shows its superiority over opium and the coal-tar products. In probably the majority of instances by which opium or a coal-tar derivative is indicated Pasadyne (Daniel) would act satisfactorily as a substitute. The physician may rely upon it. A sample bottle may be had by addressing the laboratory of John B. Daniel, 34 Wall street, Atlanta, Ga.

### The Chemistry of a Liquid Blaud.

AN IMPROVED FORM OF ADMINISTERING FRESH FERROUS CARBONATE.

BLAUD'S MASS has long been highly esteemed by the medical profession in spite of the fact that, as commonly administered, it leaves much to be desired. It is generally conceded that the ideal way to give iron is in the form of fresh ferrous carbonate. However, until the introduction of Liquid Blaud (Lilly) this has not been practicable.

Several years ago experiments were made at the Lilly Laboratories to find the best way of preserving all of the advantages of a Blaud's Mass and at the same time eliminate the undesirable features. It was discovered that anhydrous glycerin would hold ferrous sulphate and potassium carbonate in solution, and in this state they will not react to form ferrous carbonate. When the glycerin solution is mixed with water, however, the reaction takes place immediately, and ferrous carbonate is thrown down as a flocculent greenish precipitate.

The preparation is a delicate one, and great care must be exercised in bottling. All air is driven out of the bottles by displacement with carbon dioxide, and a small amount of liquid petrolatum is poured into each one. The bottles are then filled with the glycerin solution. In order not to lose the oil the bottle is shaken previous to taking, the oil is broken up minutely and is distributed through the glycerin solution. A minute amount is lost in pouring the dose, but the greater portion rises and re-forms on the surface of the liquid when the bottle is set at rest.

Lilly's Liquid Blaud is made so that each average teaspoonful (96 m.) represents 5 grains of Blaud's Mass of Ferrous Carbonate. The advantages claimed for it are obvious.

1. The patient is able to prepare fresh carbonate of iron for each dose.

2. The entire potency of the dose is at once available.

3. Ferrous carbonate enters the stomach free from the slightest obstruction to absorption.

Lilly's Liquid Blaud, in response to a demand from the medical profession, is now prepared plain, with arsenic, with strychnine, and with arsenic and strychnine, and is supplied by the drug trade. It must be dispensed in original bottles and never mixed with other drugs.

### An Important Auxiliary After Abdominal Operations.

AFTER operations upon the abdominal viscera nothing will be found to give patients more genuine comfort when ready to re-enter active life than the application of a well-fitting abdominal binder. But even more essential is its use from a strictly medical point of view. No matter how skilful the technique of suturing the divided muscles may be, there is always a risk of weakening at the point of coaptation, with resulting hernia of the abdominal wall. This condition may occur from any effort on the part of the patient that increases intra-abdominal pressure, as in the ordinary exertions of household duties or ordinary vocations, as lifting, straining, etc. For reliability, adaptability, efficiency and comfort the Storm binder and abdominal supporter (K. L. Storm, M.D., Philadelphia, Pa.), as washable as underwear (containing no whalebones, no rubber and no leather, but made of elastic weave which is perfectly flexible), has no peer and fulfills every requirement. Its originality is shown by the fact that its inventor, Dr. Katherine L. Storm, who patented the Storm binder July 10, 1906, in the United States, has recently been granted other patents upon the improvements June 18, 1912, United States. It was also patented in England May 16, 1911, and in Canada September 5, 1911.

They are very light, as has been said, and are the greatest comfort to those who need them; indeed, the writer has known patients who no longer needed them who were loath to give them up. — *Massachusetts Medical Journal.*

### After Scarlet Fever and Measles.

AFTER the acute diseases of childhood there is no remedy that will do more to hasten convalescence than Gray's Glycerine Tonic Comp. Children are particularly responsive to the tonic effects of "Gray's," and it is always gratifying to see the prompt improvement in the appetite, digestion and general nutrition that follows its administration. The palatability and clean bitter taste of "Gray's" make it exceptionally acceptable to children.

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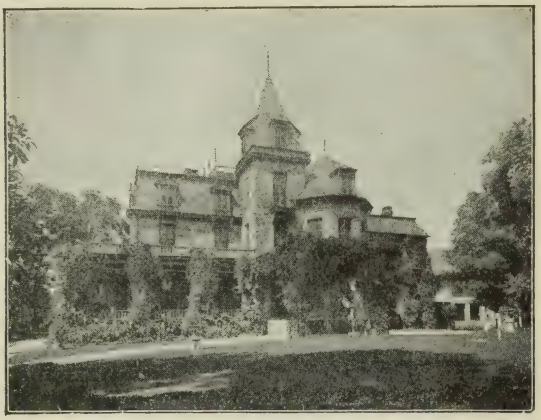

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